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ABSTRACT

The theme issue of this bulletin is a discussion of youth with emotional disturbances who are in the juvenile justice system and how to meet their needs. Articles include: (1) "Responding to the Mental Health Needs of Youth in the Juvenile Justice System" (Susan Rotenberg); (2) "Prevalence of Mental Disorders among Youth in the Juvenile Justice System" (John F. Edens and Randy K. Otto); (3) "The Trouble with Delinquent Girls" (Joanne Belknap and Kristi Holsinger), which discusses how juvenile justice service providers and parents treat girls inequitably and why girls become law-breakers; (4) "Overrepresentation of Youth of Color in the Juvenile Justice System: Culturally Competent Service System Strategies" (Marva P. Benjamin); (5) "Parents at the Front Door in Family Court and Child Welfare: Developing Parent Supports in the Juvenile Justice System" (Carol Lichtenwalter and others); (6) "The Office of Juvenile Justice and Delinquency Prevention: A Federal Partner in Meeting the Mental Health Needs of Juvenile Offenders" (Shay Bilchik); (7) "Youth with Disabilities in the Justice System: Integrating Disability Specific Approaches" (Lili Garfinkel), which addresses the impact that certain disabilities have on criminal behavior and the need to consider these influences in making adjudication and placement decisions; (8) "Multisystemic Therapy: An Effective Community-Based Alternative to Incarceration" (Scott W. Henggeler); (9) "'Intensive Aftercare' in Juvenile Corrections--The Colorado Experience" (David B. Bennett); "Bethesda Family Services Foundation 'Committed To Healing America's Families'" (Dominic Herbst); and (10) "The Virginia Intensive Parole Program" (Valerie Boykin). The Social Security Administration's new

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rules for the children's Supplemental Security Income program are also discussed. (CR)

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A NATIONAL BULLETIN ON FAMILY SUPPORT & CHILDREN'S MENTAL HEALTH

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FAMILIES, JUVENILE JUSTICE AND CHILDREN'S MENTAL HEALTH

RESPONDING TO THE MENTAL HEALTH NEEDS OF YOUTH IN THE JUVENILE JUSTICE SYSTEM

THE INNER WORKINGS OF DELINQUENT YOUTH

In the discussion on the issues of juvenile crime, the nation has ignored the prevalence of mental disorders among youth who commit crimes, and it has failed to provide policy directives on how state systems should respond. With the nation's attention riveted on youth violence, the issue of prevalence has began to emerge, with the realization that many of the violent acts are committed by a small percentage of young people. Policymakers are beginning to ask questions about the conditions that contribute to a young person's tendency toward delinquency acts.

While exact prevalence rates are not known, experts in mental health and juvenile justice estimate that the rate of mental disorder among these youth is substantially higher than among the general population of youth—possibly as high as 60 percent, compared to 22 percent in the general population of youth.[1] In 1995, an assessment conducted in the state of Virginia over a one week period revealed that more than three-quarters of all youth in the state's 17 detention facilities exhibited at least one diagnosable mental disorder. Of that number, eight to ten percent had mental health needs in the severe/urgent range and 40 percent were assessed as having needs in the moderate range.[2]

Two visions of the same child. The co-occurrence of mental health and substance abuse problems in

youth involved in the juvenile justice system has long been discussed and studied. In fact, the two problems have become intertwined as the juvenile courts move forward to rehabilitate youngsters and intervene positively in the lives of their families while the mental health system has begun to proactively treat children in their home environments.

The social science literature is abundant with references to "antisocial" youth, and juvenile justice is debating the culpability of young people and the extent to which they should be held accountable for their criminal behaviors. "Delinquency"—a legal term—has often been far removed from "conduct disorder"—a clinical term—although both describe, from different perspectives, a child who does not stay within the bounds of accepted behaviors in our society. These two visions of the same child have hampered our ability to address the mental health needs of

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PREVALENCE OF MENTAL DISORDERS AMONG YOUTH IN THE JUVENILE JUSTICE SYSTEM

Despite increasing interest in the mental health needs of children involved in the juvenile justice system, relatively little is known about the base rates of specific mental disorders in this population due to the absence of any national prevalence data. In 1992, two reviews of the existing empirical literature (Otto, Greenstein, Johnson, Friedman, 1992; Wierson, Forehand, & Frame, 1992) both concluded that relatively few well-controlled epidemiological studies had been conducted that could inform our knowledge of the prevalence of mental disorders in the juvenile justice system. Factors commonly cited that limited the generalizability of much of the existing research included: (a) failure to use random or comprehensive sampling procedures, (b) use of differing assessment instruments across studies or reliance on file information rather than structured diagnostic interviews, (c) assignment of only one diagnosis and failure to assess for multiple diagnoses/comorbidity, (d) samples being drawn from only one site or state, and (e) failure to consider how diagnostic rates might be affected by relevant demographic and historical variables such as age, gender, and length of detainment. Since the publication of these two reviews,

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We invite our audience to submit letters and comments.

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RESPONDING TO THE MENTAL HEALTH NEEDS OF YOUTH IN THE JUVENILE JUSTICE SYSTEM CONTINUED

delinquent populations. They have also sent researchers and practitioners in vastly different directions in planning policy and practice to respond to the rising fear of youthful lawlessness, violent crime, and the perceived anomie of a growing number of today's adolescents.

FRONT END SERVICES: A LOOK INSIDE THE JUSTICE SYSTEM FOR POTENTIAL INTERVENTION POINTS

Soon after a referral to juvenile court, a decision is made to handle the case formally or informally. Informal processing is considered when decisionmakers believe that accountability and rehabilitation can be achieved without the use of formal court intervention. This juncture may be an intervention point for addressing youths' mental health needs. Informal sanctions are voluntary; the court cannot force a juvenile to comply with an informal disposition. If the decision is made to handle the matter informally, an offender may agree to perform community service work, pay victim restitution, submit to voluntary probation services, or comply with a range of other sanctions.

Informal Dispositions Present a Tremendous Opportunity as a Referral Resource for Mental and Substance Abuse Problems Identified at Intake Stage. In many jurisdictions before juveniles are offered informal sanctions they must admit that they committed the alleged act. Cases are held open pending completion of informal dispositions. Charges are than dropped after successful completion. Informal handling is common in the juvenile courts. In 1992, half (51%) of delinquency cases were handled informally. These cases present a tremendous opportunity for courts to become involved as a referral source for mental and substance abuse problems identified at intake stage. In 1992, informal court handling was most common for delinquency cases in which a property offense was the most serious charge. Drug cases were the least likely to be handled informally. Whereas the use of informal processing remained fairly constant between 1988 and 1992 for most offenses, informal handling declined somewhat for cases involving drug law violations.[3]

More than half (53%) of the informally handled delinquency cases processed in 1992 involved some type of services or sanctions beyond the warning and counseling of the youth. These cases consist of a significant number of youngsters who might have benefited from referrals or clinical interventions. In nearly a third (30%) of informally processed cases, the youth agreed to a term of voluntary probation supervision, and 23% agreed to other sanctions such as voluntary restitution, community service, or referral to another agency. In a very small number of cases, the youth and their families agreed to a period of out-of-home placement as a result of the court's action.[4]

Probation Departments See Large Numbers of At-Risk Youth. The juvenile probation function within the juvenile court is the front line for identifying, assessing, planning, and delivering services to youth with substance abuse and/or mental health problems. In one fashion or another, juvenile probation, in most states, "lays hands" on every young person referred to juvenile court. With a steady flow of incoming cases, probation departments see more at-risk youth than any other social service entity, with the possible exception of schools. It is clear the working relationship between probation and the mental health system must be reliable, trusting, and rational if early interventions are to take hold in this adolescent population.[5]

Between 1988 and 1992, probation was the most severe disposition used by juvenile courts in nearly two of every five delinquency cases and in nearly three of every five adjudicated cases, with the annual proportions remaining consist over this period. Therefore the growth in probation caseloads was directly related to the general growth in referrals to juvenile court.[6]

KEY ISSUES REGARDING DETENTION FACILITIES

One key issue is whether detention facilities provide treatment. Some advocates claim current treatment facilities have not changed in the years since the major lawsuits seeking adequate facilities were litigated. These inadequate juvenile facilities scarcely embody the therapeutic goals they are suppose to represent; and are plagued with violence, predatory behavior and punitive incarceration.

A recent study by the US Department of Justice's Office of Juvenile Justice and Delinquency Prevention [7] on conditions of confinement includes a survey of mental health treatment services at 95 private and public juvenile facilities around the nation. Researchers assessed whether juveniles are in facilities with a minimal counselor to juvenile ratio (one counselor per 25 residents. The study showed that 87% of the facilities satisfied the counselor ratio. Additionally, most treatment programs dealt strictly with drug and alcohol abuse, as opposed to mental illness. Further, the lack of an effective measure of treatment prevented researchers from determining whether facilities provide treatment or what, if any, benefits juveniles may receive from the programs.

A 1974 study by researcher Robert Martinson analyzed correctional treatment programs and concluded that "nothing works." Critics have cited this study to oppose funding rehabilitation programs for juvenile and adults.[8] Most studies show that rehabilitation programs do produce positive changes under certain conditions. Yet, there still exists a reluctance among state and local governments to allocate sufficient resources to address or improve treatment programs.[9]

Needs of culturally diverse youth. Advocates suggest that reforms brought about by *Wyatt v. Stickney*, (establishing standards for persons with mental illness or mental retardation),[10] must also address the concerns of minority overrepresentation in the juvenile justice system. One approach is the introduction of cultural competence standards. Cultural competence refers to an understanding of the beliefs, values and customs of minority youth. This approach suggests that "traditional" methods of treatment must be adapted to meet the needs of culturally diverse youth. One medical professional has suggested that, for practitioners, cultural competence includes establishing a knowledge base of differential diagnoses, developing new skills and abilities, and re-examining attitudes towards patients from different cultures.[11]

In addition, many states are beginning to develop cultural competency standards for mental health services. For example, in 1995, the California Mental Health Directors Association began developing such standards in an effort to address the needs of the state's diverse ethnic population.[12] The proposed standards include cultural factors such as belief, values, health and healing practices. These standards also emphasize the need for cultural competence at all levels of mental health organizations including access to care, quality of care, and prevention.[13]

THE NATIONAL COALITION FOR MENTAL AND SUBSTANCE ABUSE HEALTH CARE IN THE JUSTICE SYSTEM.

In 1992 members of the National Coalition for Mental and Substance Health Care in the Justice System worked successfully with members of the United States Congress. The Juvenile Justice and Delinquency Prevention Act of 1993 includes a provision that reconizes the importance of addressing the needs of youth who have mental health disorders.

In 1993 the National Coalition developed a State Policy Design Academy for state governments to work toward potential solutions to juvenile crime issues. State governors applied to the Academy on a competitive basis for the opportunity to send teams of high-level policymakers to the Academy with the goal of creating new solutions for the states' respective juvenile crime problems. The selection criteria included a requirement that parents serve on each team. A key criterion for selected teams was a commitment by each state governor to stand behind the work developed at the Academy. The National Coalition has worked with 14 states and the Navajo Nation.

In May 1992 the National Coalition held a national work session to lay the groundwork for their youth initiative. As an outgrowth of that meeting the National Coalition published *Responding to the Mental Health Needs of Youth in the Juvenile Justice System*. This publication represents the state-of-the-art with respect to our knowledge about this population group and the prevalence of mental illness. Representatives from fifty-five national associations participated in the work session and in the creation of this state-of-the-art publication which promotes the socially responsible development of public policy in the juvenile justice arena. Eleven priorities for the provision of mental health services for children in the juvenile justice system emerged from the work session:

1. **Research** is needed to develop screening and assessment tools to determine mental health intervention needs of youth as they enter into the juvenile justice system.
2. **Interagency collaboration** is needed to provide an expanded range of services and to bring agencies together in a collaborative effort, in addition to developing new financing mechanisms.
3. **Neighborhood-driven programs** are needed within communities to play a catalytic role with public agencies involving families in management and decisionmaking.
4. **Education** for juvenile justice and mental health personnel is necessary to increase awareness of the special needs of youth with mental illness, including culturally competent evaluations and treatment.
5. **Assessment of amenability to treatment** is a critical issue. The courts' decisions are typically based on whether a child can fit into existing treatment models, not upon whether the mental illness is treatable. The issue is complicated by determinations being based on the variability of mental health professionals' expertise and upon the availability of resources.
6. **Treatment specificity** must be determined. That is, differentiation of solutions from successful models that meet the needs of inner city youth and those that meet the needs of suburban or rural youths must be found.
7. **Funding mechanisms** must be re-

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tooled. A major barrier to the provision of services for this population group is the categorical nature of federal, state, and local funding. Successful models have been achieved only when funding is adapted to the needs of youthful offenders and their families.

8. **Diversion programs** must be developed as alternatives to incarceration. A major emphasis is needed on programs that keep youth out of the juvenile justice system and in the least restrictive setting that is clinically appropriate, while at the same time protecting public safety.

9. **Stigma** must be reduced. To make progress, we need to "put a human face" on this issue. We must visualize our friends or their children as the person with mental illness or as the child "in trouble." This will help reduce the stigma faced by families in general, and those who end up in the juvenile justice system in particular.

10. **Dissemination of information** must be increased. Emerging trends and challenges impact the retention of youth in trouble. New paradigms for knowledge dissemination and utilization must be employed.

11. **Participatory treatment** must be emphasized. Youth and families must be involved with treatment providers in assessing service needs and in developing strategies for service provision.

THE NATIONAL COALITION'S FUTURE.

During the years 1989-1995 the National Coalition was the recipient of a sole source federal grant. With 76 other participating organizations the National Coalition achieved its funded mission to bring the issues of youth and adults who have mental health needs in the justice system to the forefront. The National Coalition is currently in the midst of transition. Today, as the Coalition's originator and prime mover, I have returned to child welfare and have made a two-year commitment to address child abuse issues. I am working with others to launch a grass roots national project for domestic peace. Please feel free to contact me for information on the National Coalition's next phase.

SUSAN ROTENBERG M.A. PSY. *Past Executive Director, National Coalition for Mental & Substance Abuse Health Care in the Justice System. Department of Social and Health Services, Division of Children and Family Services, 1949 South State Street, Tacoma, Washington, 98405-2850; (206) 284-6009 (voice); (206) 593-2922 (fax).*

REFERENCES

1. OJJDP Work Session "Caring for Every Youth's Mental Health: Inseparable issue from Youth Crime" Seattle, Washington, National Coalition for Mental & Substance Abuse Health Care in the Justice System
2. OJJDP Work Session et al ., 1995
3. Hurst, H.,& Tobert P. (1993) *Organization and Administration of Juvenile Services: Probation Aftercare and State Institutions for Delinquent Youth*. Pittsburgh, PA: National Center for Juvenile Justice.
4. Butts, J., H., Finnegan, T., Aughenbauth, A Tierney, N., Poole, R., Sickmound, M., & Poe, E. (1995). *Juvenile Court Statistics 1992*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention.
5. Snyder, H.N. & Sickmound, M. (1995) *Juvenile Offenders and Victims: A National Report*. Washington DC: Washington, DC: Office of Juvenile Justice and Delinquency Prevention.
6. National Center for Juvenile Justice. (1991) *Desktop Guide to good Juvenile Probation Practice*. Washington DC: Office of Juvenile Justice and Delinquency Prevention.
7. Dalle G. Parent et al., U.S. Dept of Justice, *Conditions of Confinement and Corrections Facilities* (1994)
8. Brooks, J. P., *Addressing Recidivism: Legal Education in Correctional Settings*, 44 Rutgers Ll. Rev. 699, 713 (1992) See also Imogene M. Montgomery et al., U.S. Dept. of Justice, *What Works: Promising Interventions in Juvenile Justice* (1994).
9. Sunderman, G., Nebraska Bar Is Told Jailing Youth Costly Prevention Effort Urged By Specialist, *Omaha World Herald*, Oct 20, 1995, at 19.
10. *Wyatt v Stickney*, 344 F. Supp. 373 (M.D. Ala. 1972) establishing standards for mentally ill) *aff'd in relevant part*, 503 F.2d 1305 (5th Cir. 1974); *Wyatt v Stickney*, 344 F. Supp. 387 (M.D. Ala 1972) establishing standards for mentally retarded), *aff'd in relevant part*, 503 F.2d 1305 (5th Cir. 1974).
11. Voelker,R., Speaking the Languages of Medicine and Culture, *J. of the Am. Medical Assn.*, June 7, 1995 at 21.
12. California Mental Health Ethnic Services Managers (August, 1995). *Cultural Competency Goals, Strategies, and Standards for Mental Health Care to Ethnic Clients*.
13. California Mental Health Ethnic Services Managers, August 1995

NEW WORLD WIDE WEB ADDRESS

The Research and Training Center has changed the address for its site on the World Wide Web. The new address is *http://www.pdx.rtc.edu*

The RTC's website contains:

- Descriptions of all Center projects;
- Updated lists of all Center publications, with ordering information;
- Full text and graphics of *Focal Point*;
- National Clearinghouse on Family Support and Children's Mental Health;
- Mental health fact sheets;
- Glossaries of research terms, acronyms, children's mental health terms, and laws and regulations;
- Reports and photos from the 1997 *Building on Family Strengths Conference* (conference proceedings will be available for downloading soon); and
- Links to other mental health websites of interest.

Shad Jessen

The RTC's web site, created and maintained by Shad Jessen, recently received an award from Mental Health Net (http://www.cmhc.com) for excellence in content, design and navigation.

PREVALENCE OF MENTAL DISORDERS AMONG YOUTH IN THE JUVENILE JUSTICE SYSTEM CONTINUED

few studies have been conducted that have significantly improved our knowledge of the prevalence of mental disorders in juvenile justice populations and national prevalence estimates of mental disorder still have not been established.

Despite the limitations of existing research on the prevalence of mental disorders in the juvenile justice system, some tentative estimates can be provided for specific diagnostic categories, as well as for other clinically significant issues such as a history of child abuse, suicidal behavior, and prior mental health treatment. The following base rates are distilled from the Otto et al. (1992) and Wierson et al. (1992) reviews, as well as from more recent research, and include only those studies that used comprehensive or random sampling procedures. Given the methodological limitations already mentioned, particularly regarding the common failure to assess for co-occurring disorders, these rates should be considered as conservative estimates of the prevalence of these disorders. As well, none of the rates recited here are from studies that employed *DSM-IV* (American Psychiatric Association; APA, 1994) diagnostic criteria. Most of the rates reported are based on earlier versions of the *DSM* and used what are now outdated criteria for most diagnostic categories.

DIAGNOSES

Conduct Disorder: As might be expected, conduct disorder appears to be the most prominent diagnosis among youth in juvenile justice settings, with most studies reporting prevalence to be greater than 80%. Depending on diagnostic criteria used and assessment methods employed, however, exact base rates vary considerably from study to study. This is due, in part, to changes in the *DSM* criteria over the years. For example, Adam, Kashani, and Schulte (1991) showed significant changes in the base rate of conduct disorder in their sample depending on whether *DSM-III* (APA, 1980) or *DSM-III-R* (APA, 1987) criteria were employed. Typically, however, prevalence estimates have ranged between 50% and 90% in most well-controlled studies. This high rate is not surprising, given that the diagnostic criteria for conduct disorder include various types of delinquent and criminal behavior.

Substance Abuse: Rates of substance abuse or dependence generally have been reported to range between 25% and 50%, although rates of up to 69% also have been reported. These rates of abuse or dependence should not be confused with rates of substance use, which are considerably higher. Many juveniles (13% - 25%) also report a history of substance abuse treatment. Evidence from adult populations suggests that substance abuse co-occurs with major Axis I mental disorders with greater frequency in criminal justice settings than in the general population (Edens, Peters, & Hills, 1997). Although this relationship has not been studied as extensively in juveniles, there is evidence to suggest that a high level of comorbidity is also evident in children and adolescents in the juvenile justice system.

Attention-Deficit/Hyperactivity Disorder (ADHD): The prevalence of ADHD has varied widely from study to study, with rates ranging from 0% to 46%. Studies using clinical interviews have generally reported higher rates than those employing behavioral rating scales or checklists. The failure to assess for comorbidity with conduct disorder and the tendency to assign only one diagnosis may also account for the low base rate of ADHD in some studies. Conduct problems and ADHD have been shown to co-occur with great consistency in the general population (see Hinshaw (1987) for a review). Furthermore, it has been documented that juvenile delinquents diagnosed with both conduct disorder and ADHD have a greater number of total arrests and tend to be arrested at an earlier age than delinquents with conduct disorder who do not also have ADHD (Forehand, Wierson, Frame, Kempton, & Armistead, 1991).

Affective Disorders: Rates of affective disorders such as major depression, bipolar disorder, dysthymia, and cyclothymia have ranged between 32% and 78% in studies of juveniles that used diagnostic interviews. Investigators not employing interviews generally have reported much lower prevalences, ranging from 2% to 12%. Given the relatively high comorbidity between conduct and affective disorders in the general population (see McConaughy and Skiba (1993) for a review), some authors have argued that antisocial behavior or aggression in juveniles may be an indirect manifestation of their depressive disorder (Ney, Colbert, Newman, & Young, 1986). Also, there appears to be a greater tendency for affective disorders to co-occur with substance abuse problems in juvenile justice settings than in the general population.

Anxiety Disorders: Base rates of anxiety disorders have varied widely, with studies employing clinical interviews typically reporting higher prevalence (6% - 41%) than those not using interviews (0% - 7%). More recent research specifically examining Post Traumatic Stress Disorder (PTSD) in incarcerated delinquents has suggested that PTSD tends to co-occur with other mental disorders such as substance abuse and conduct disorder at a high frequency, particularly among children exposed to serious interpersonal violence (Steiner, Garcia, & Matthews, 1997). This is a significant finding, given that most prior studies have not examined the prevalence of PTSD symptoms in their samples.

Psychotic Disorders: Relatively few studies have examined base rates of psychotic disorders in the juvenile

justice system. Rates typically have been higher than in the general population, ranging from 1% to 6% in the few studies employing comprehensive or random sampling methods.

Personality Disorders: Although typically not diagnosed before the age of 18, a few studies have reported base rates of personality disorders in juvenile justice samples. These generally have been low (2% - 17%), although rates as high as 46% have been reported. Most researchers typically have not differentiated between subtypes of personality disorders in these studies, which makes their findings difficult to interpret. However, some research has shown that antisocial, sociopathic, or psychopathic personality features appear to be associated with higher rates of recidivism in juvenile delinquents than in delinquents without these personality features (Ganzer & Sarason, 1972; McManus, Alessi, Grapentine, & Brickman, 1984).

Mental Retardation: Rates of mental retardation have been reported by the Institute on Mental Disability and the Law at the National Center for State Courts (1987) to be approximately 13%. Other studies have reported similar rates, ranging from 7% to 15%, depending on the specific intellectual tests employed and the exact diagnostic criteria used.

Learning Disabilities/Specific Developmental Disorders: The Institute on Mental Disability and the Law at the National Center for State Courts (1987) also reported that approximately 36% of children in the juvenile justice system meet diagnostic criteria for learning disabilities. Other studies have varied considerably, reporting prevalences ranging from 17% to 33%.

CLINICAL CONDITIONS

Child Abuse: Although the deleterious effects of child abuse and neglect on children's functioning have been clearly documented, only a few studies have addressed the prevalence of these experiences among youth in the juvenile justice system. Those few studies that have systematically examined rates of child abuse have been highly consistent, however, with rates ranging between 25% and 31%.

Suicidal Behavior: Although studies have varied regarding definitions of suicidal or self-injurious behavior, they typically have reported rates of previous suicide attempts ranging between 6% and 28%. Findings have usually been based on either self-report or information obtained from file reviews. Not surprisingly, these rates are significantly higher among delinquents with major affective disorders.

Prior Mental Health Treatment: Investigators examining rates of psychiatric hospitalization among children in the juvenile justice system generally have reported rates between 12% and 26%, although rates as low as 3% also have been reported. Outpatient treatment appears to be much more common among youth involved in the juvenile justice system, with rates ranging between 38% and 66% in studies using random or comprehensive sampling procedures.

CONCLUSIONS

Although far from conclusive, a few general trends can be identified in the studies that have been conducted to date. First, these results clearly suggest that the prevalence of mental disorders in juvenile justice settings are considerably higher than in community samples of children and adolescents (Costello, 1989; Otto et al., 1992; Wierson et al., 1992), with conduct disorders being by far the most common diagnosis. Second, comorbidity appears to be relatively high, but has not been adequately assessed in the majority of studies. In particular, the reporting of only one psychiatric diagnosis by many investigators has probably led to underestimations of ADHD, PTSD, and affective disorders in juvenile justice populations. Third, paralleling what we know about adults, substance use and abuse appears to be a significant risk factor for delinquency and also seems to co-occur with other Axis I disorders at a rate much higher than in the general population. Finally, base rates of mental disorders can be significantly influenced by changing diagnostic criteria. As diagnostic criteria continue to evolve, it is likely that the prevalence of specific disorders will change as well.

The need for a multi-state epidemiological study of mental disorders among youth in the juvenile justice system has been pointed out previously by several authors (Hoagwood, 1994; Otto et al., 1992; Wierson et al., 1992). Despite the intrinsic difficulties of conducting such research, it remains necessary before any conclusive statements can be made regarding the prevalence of mental disorders in the juvenile justice system. The results of such a study would have significant implications regarding the screening, assessment, treatment, and disposition of these children.

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REFERENCES

American Psychiatric Association. (1980) *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders*(4th ed.). Washington, DC: Author.

Costello, E.J. (1989). Developments in child psychiatric epidemiology. *Journal of the American Academy of Child and Adolescent Psychiatry, 28*, 836-841.

Edens, J.F., Peters, R.H., & Hills, H.A. (1997). *Treating prison inmates with co-occurring disorders: An integrative review of existing programs*. Manuscript submitted for publication.

Forehand, R., Wierson, M., Frame, C., Kempton, T., & Armistead, L. (1991). Juvenile delinquency entry and persistence: Do attention problems contribute to conduct problems? *Journal of Behavior Therapy & Experimental Psychiatry, 22*(4), 261-264.

Ganzer, V.J., & Sarason, I.G. (1972). Variables associated with recidivism among juvenile delinquents. *Journal of Consulting and Clinical Psychology, 40*, 1-5.

Hinshaw, S.P. (1987). On the distinction between attentional deficits/ hyperactivity and conduct problems/ aggression in child psychopathology. *Psychological Bulletin, 101*, 443-463.

Hoagwood, K. (1994). Introduction to the special section: Issues in designing and implementing studies in non-mental health care sectors. *Journal of Clinical Child Psychology, 23*, 114-120.

Institute on Mental Disability and the Law. (1987). *The prevalence of mental disabilities and handicapping conditions among juvenile offenders*. Williamsburg, VA: National Center for State Courts.

McConaughy, S. H., & Skiba, R. J. (1993). Comorbidity of externalizing and internalizing problems. *School Psychology Review, 22*, 421-436.

McManus, M., Alessi, N.E., Grapentine, W.L., & Brickman, A. (1984). Psychiatric disturbance in serious delinquents. *Journal of the American Academy of Child Psychiatry, 23*, 602-615.

Ney, P., Colbert, P., Newman, B., & Young, J. (1986). Aggressive behavior and learning difficulties as symptoms of depression in children. *Child Psychiatry and Human Development, 17*, 3-14.

Otto, R.K., Greenstein, J.J., Johnson, M.K., & Friedman, R.M. (1992). Prevalence of mental disorders among youth in the juvenile justice system. In J.J. Cocozza (Ed.), *Responding to the mental health needs of youth in the juvenile justice system*. Seattle, WA: The National Coalition for the Mentally Ill in the Criminal Justice System.

Steiner, H., Garcia, I.G., & Matthews, Z. (1997). Posttraumatic stress disorder in incarcerated juvenile delinquents. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*, 357-365.

Wierson, M., Forehand, R.L., & Frame, C.L. (1992). Epidemiology and treatment of mental health problems in juvenile delinquents. *Advances in Behaviour Research and Therapy, 14*, 93-120.

THE TROUBLE WITH DELINQUENT GIRLS

JUVENILE JUSTICE SERVICE PROVIDERS TREAT GIRLS INEQUITABLY

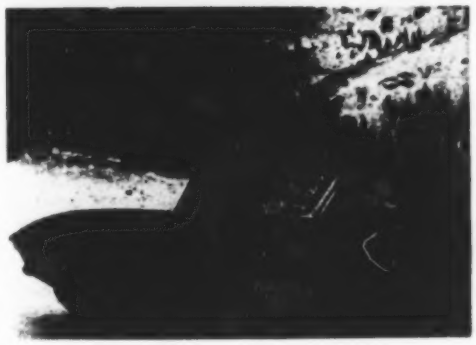
Girls and boys in the juvenile justice system are typically treated quite differently. There are a variety of general gender distinctions both in *pathways to law-breaking* and *responses to these juvenile lawbreakers*. Moreover, these gender differences in pathways and systemic responses are almost exclusively to the disadvantage of girls. Research on juvenile delinquency shows that both historically and currently, girls are overall processed far more seriously than boys for delinquency, particularly status crimes (Chesney-Lind & Shelden, 1992). The processing and institutionalization of African American girls is particularly unfair (see Young, 1994).

There is an abundance of research highlighting sexism regarding the increased likelihood of girls being institutionalized for status offenses. In addition, the conditions of female delinquents' institutions are considerably worse than boys' (Chesney-Lind & Shelden, 1992), and delinquent girls experience additional risks of sexual victimization by male staff and other inmates (Chesney-Lind & Rodriguez, 1983). Similar to women's prisons, female delinquent institutions often serve to reinforce traditional gender roles and perpetuate stereotypes (Gelsethorpe, 1989). Typically, girls are rewarded for feminine behavior and punished for being assertive or behaving like "tomboys" (Belknap, et al. 1997; Gelsethorpe, 1989).

Chesney-Lind (1973, 1974) documented how girls are more likely than boys to be picked up and labeled for status offenses. Whether the "offense" was consensual sexual activity or not, there has been a historical preoccupation with women's and girls' "promiscuity"—a term we never see applied to males—in meting out justice (and this is true for both female offenders and female rape victims). Chesney-Lind's (1973, 1974) early work documented how female status offenders, regardless of their charged offenses, were frequently given gynecological exams to determine whether they were virgins. (Given that such exams were often against their will, they qualify for our definition of rape (see Belknap 1996).) If these delinquent girls were deemed sexually active from these exams, further charges were brought against them. Unfortunately, a preoccupation with female "promiscuity" still exists (see, for example, Chesney-Lind & Shelden, 1992; Sanday, 1996).

PARENTS TREAT DAUGHTERS INEQUITABLY

Researchers have documented that both parents and workers in the juvenile and criminal "justice" systems respond differently to girls and boys, usually to girls' disadvantage. For example, parents generally have stricter rules for their daughters than their sons in setting curfews, the consequences of violating curfews, drinking alcohol, using drugs, being sexually active, and other activities. Moreover, parents respond more seriously to daughters than sons who have violated "house" rules, and are more likely to turn their daughters than their sons into the police for the same activities (Chesney-Lind & Shelden, 1992).



WHY DO GIRLS BECOME LAW-BREAKERS?

One of the most important findings in criminological research in recent years is the distinct gender differences in "pathways" to law breaking (Arnold, 1990; Chesney-Lind & Rodriguez, 1983; Daly, 1992; Gilfus, 1992; Lake, 1993; Silbert & Pines, 1981). Although girls and boys have some of the same pressures in their lives, and sometimes the same access to learning criminal behavior, the reality is that the reasons girls and boys turn to crime are often quite different. In particular, the scholars noted above have documented how girls' abusive histories, frequently including incest, are often related to their getting into crime.

Empirical research demonstrates that many of the girls involved in the juvenile justice system are survivors of sexual and physical abuse. Chesney-Lind (1989) has written that daughters are referred to court by parents more often than sons. One reason girls have conflict with their parents is related to physical and sexual abuse within the family which is a more common occurrence for girls than boys, starts at an earlier age, and lasts longer. Studies of girls on the streets or in the courts show high rates of abuse (Silbert and Pines, 1981; Mouzakitas, 1981; Phelps et al., 1982; McCormack, Janus, & Burgess, 1986; Reich & Gutierres, 1979; Chesney-Lind & Rodriquez, 1983; Widom, 1988).

Dembo, Williams and Schmeidler (1993) collected data on 399 male and female youth entering a juvenile detention center. Females were more often sexually victimized and had higher rates of referral to juvenile court for being sexually abused/exploited. Sixty-one percent of females were sexually victimized at least once in their lives. The results are consistent with the view that the girls' problem behavior commonly relates to an abusive and traumatizing home life, whereas the boys' law violated behavior reflects their involvement in a delinquent lifestyle. A seriously troubled home life appears to be a more significant factor in female delinquency.

This is certainly not to say that all sexually abused girls become delinquents, nor is it to say that all delinquent girls are sexual abuse survivors. It is important to note, however, that incarcerated females report disproportionately high rates of sexual abuse compared to their counterparts in the community. For example, a review of research on the prevalence of child sexual abuse among community (non-institutionalized) samples found that prevalence rates ranged from 5 to 45 percent (Wyatt, Newcomb & Riederle, 1993). On the other hand, Chesney-Lind and Shelden's (1992) review of similar studies on delinquent (non-community) girls reported a range of physical and sexual abuse rates from 40 to 73 percent, and Dembo and his colleagues found that 65 percent of female (and 24% of male) juvenile detainees reported sexual abuse victimization (Dembo et al., 1992).

Other factors, outside of or in addition to family physical and sexual abuse have been found to be related to girls' delinquency. Sommers and Baskin (1994) report that neighborhoods with a high concentration of poverty, dropping out of school, getting in with the "wrong" crowd, and stranger-perpetrated physical and sexual abuse all may contribute to female delinquency. Chesney-Lind and Shelden (1992, p. 98) suggest that in order "to explain delinquency among girls it is necessary to begin considering the importance of gender stratification in a patriarchal society, especially because it is so important in shaping the daily lives of boys and girls." Regarding mental health and its relationship to female delinquency, girls are at increased risk for internalizing problems, which are frequently manifested by withdrawal, depression, emotional problems, and self-destructive behaviors (Dembo et al., 1993; Wells, 1994; Widom, 1989).

It is also important to recognize that "good" and well-intentioned parents can have delinquent daughters (and sons). Although "good" parenting decreases the likelihood of offspring offending, it is no guarantee. Upheavals in a child's life, such as changing schools, moving, the death of a family member or friend, and parents' divorce can all increase the risk of delinquent behaviors and "acting out" (see, for example, Farrington, 1994). Understandably, both delinquent behavior *and* dealing with the juvenile processing system can be very frustrating for parents who have been dedicated to raising law-abiding children. It is important, however, for a parent to try to maintain or re-establish a close relationship with the delinquent child despite the frustration the delinquency has caused. Clearly, some parents of offending girls have exercised extreme patience and love in attempting to see their daughters through drug and other delinquency problems, and even this is not always successful in stopping their daughters' offending.

In our own research on delinquent girls, the overwhelming need that the girls reported was *respect* (Belknap, Dunn & Holsinger, 1997). They wanted respect from their parents, friends, teachers, police officers, social workers, and institutional staff. Most of these girls needed someone who "believed" in them. Mary Pipher (1994) convincingly argues how some girls' delinquency is an attempt to rebel and separate from their parents. Pipher stresses the importance of family bonds and recommends politicizing rather than pathologizing families

in order to enable girls to more effectively stand up to the sexist and negative effects of the culture and to help girls learn positive ways to be independent.

THE TYPICAL STORY OF SEXUALLY ABUSED DELINQUENT GIRLS

It is also necessary to tackle head-on the devastating effects of family abuse for some girls, and how for some it is the beginning of their "road" to crime. The story usually goes something like this: the girl is sexually abused by her father or step-father, the girl runs away from home to escape the abuse, the girl turns to prostitution to survive, the girl turns to drugs as "self-medication," and the girl turns to selling drugs to support a drug habit or to make money to live. Anywhere in here the girl might have become a woman, and anywhere in here the girl might have been processed by the juvenile or criminal justice system. Additionally, if the girl (or woman) is African American, Hispanic, or Native American, her chances of being formally processed and labeled "delinquent" increase.

Of course there are variations in this theme. In many cases the abuse is non-sexual physical abuse in addition to or instead of the sexual abuse. And, like the sexual abuse, much of this abuse is extreme and severe. There are girls, runaways and non-runaways, who get involved with abusive men—often twice their age or older—who get them hooked on drugs, committing robberies, and prostituting. There are girls who learn to use drugs in their own homes from their parents, who can't remember a time period when they didn't see their parents using drugs. (In our own work we witnessed this more often among Anglo than African American girls, contrary to popular stereotypes.) When institutionalized, these girls have understandable fears about how they are going to stay off drugs when they are released back into these same homes— the homes where they were abused and/or where their other family members use drugs on a daily basis. It is even more puzzling to try to understand why the abusive and drug-using parents are at home while their daughters are institutionalized as "delinquents."

The same system that can't seem to find a way to do anything about their sexually abusive fathers and step-fathers, sometimes determines that the best holding place for girls whose only offense is running away from victimization, is some type of juvenile delinquency institution (Chesney-Lind & Shelden, 1992). While many mothers act quickly to protect their children upon learning of their abuse, others are aware of their daughters' victimization and fail to protect them from their abusers. There are girls whose mothers have been given the options "either move away from or kick out the sexually abusing father/step-father/mother's boyfriend, or your daughter is going to be taken away," whose mothers have opted for living with their daughters' sexual abusers.

We have talked to some of these girls and their stories are heart-breaking (Belknap, Dunn, & Holsinger, 1997). One girl in this situation talked in a detached manner about how her mother had chosen to live with her new boyfriend (over living with her daughter), knowing the boyfriend had sexually abused her. The night before the daughter was supposed to go to her new foster home (since her mother wouldn't boot out her abuser), the daughter went out with friends and, in a rage, committed a violent crime.

The recent concern in the media (which is an on-going, cyclical concern) about the "new" (read violent) female offender may once again be exaggerating the violence among these girls. (Our research suggests that their violence levels haven't risen any more than boys, overall.) This is not to say, however, that some of them aren't extremely violent. Many of the institutionalized girls we interviewed were very angry, usually understandably, about their life situations. They were angry about the constant abuse and degradation they experienced in their homes, schools, and communities. They were angry about how they had been treated by police, judges, and correctional staff. And they were angry that the violence they *witnessed* was an everyday part of their lives. We were continually amazed at the accounts of watching a father murdered by an uncle, a brother shot, and so on. The fact that more of the girls are *not* violent is more puzzling than that some of them *are* violent.

INCREASED RISK OF FUTURE BATTERING

While these girls' abusive histories may not justify or excuse their offending activities, particularly the violent crimes, they certainly make them more understandable. Even more importantly, they point to the need to identify these high-risk girls *before* they have gotten on the pathway to law breaking, or at least attempt effective intervention when they are first formally processed. In addition to the non-sexual and sexual physical abuse these girls receive in childhood increasing their likelihood of offending, this childhood abuse also places them at increased risk of being battered by their intimate male partners (i.e., husbands and boyfriends).

Moreover, research has documented how many of the women imprisoned in the United States today are there for crimes directly related to their battering (e.g., Daly, 1992). There are batterers who coerce women to commit crimes (e.g., carry or sell drugs), threatening to beat them if they don't comply. Prisons across this country hold women who have killed their batterers in self-defense or hired someone to do so in attempts to get away or save their children from abuse (Browne, 1987). *In short, then, girls' and women's victimizations and offending are often cyclical in nature, and very much related to each other.*

Currently, there is little available for delinquent girls, or even non-delinquent girls who have run away from abusive homes (Wells, 1994). The root of their problems rarely seem

to be very important to anyone. Further, we have juvenile and criminal "justice" systems that are frequently overburdened and unable to deal with these problems—and so the girls lose.

But it is not just the girls who lose. Warehousing these girls in delinquent institutions that fail to give them the counseling, educational, athletic, vocational and health services they need, usually results in them being in and out of court, prison, and mental health systems for a good portion of their lives—and warehousing costs a lot of money. More importantly, this warehousing "breeds" crime. These girls often have children at some point, and their children are usually placed in foster homes or are relinquished for adoption, or are moved about from one "home" to another, often separated from their siblings as well as their mothers, in turn placing *these children* at risk for offending. (Not to mention the lack of appropriate prenatal care involved in most of these delinquent girls' pregnancies.)

So if it is not out of concern for these girls' lives, change needs to occur simply because it makes more fiscal sense and more compassionate responses will have a more significant impact on actually deterring crime. These girls deserve more in terms of services, responses, and intervention earlier in their lives, when things first start going wrong for them. This is not only the most humane response to this problem, but it makes the most fiscal sense and it is the response most likely to deter crime.

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REFERENCES

Arnold, R.A. (1990). Women of color: Processes of victimization and criminalization of black women. *Social Justice*, 17(3), 153-166.

Belknap, J. (1996). *The invisible woman: Gender, crime, and justice*. Cincinnati: Wadsworth Publishing Company.

Belknap, J., Dunn, M., Holsinger, K. (1997). *Moving toward juvenile justice and youth-serving systems that address the distinct experience of the adolescent female*. A Report to the Governor. Office of Criminal Justice Services, Columbus, OH.

Browne, A. (1987). *When battered women kill*. New York: Free Press.

Chesney-Lind, M. (1973). Judicial enforcement of the female sex role: The family court and the female delinquent. *Issues in Criminology*, 8(2), 51-69.

Chesney-Lind, M. (1974). Juvenile delinquency: The sexualization of female crime. *Psychology Today*, July, 43-46.

Chesney-Lind, M. (1989). Girls' crime and woman's place: Toward a feminist model of female delinquency. *Crime and Delinquency*, 35(1), 5-29.

Chesney-Lind, M. & Rodriguez, N. (1983). Women under lock and key. *Prison Journal*, 63, 47-65.

Chesney-Lind, M. & Shelden, R.G. (1992). *Girls, Delinquency and Juvenile Justice*. Pacific Grove, CA: Brooks/Cole.

Daly, K. (1992). A women's pathway to felony court. *Review of Law and Women's Studies*, 2, 11-52.

Dembo, R., Williams, L. & Schmeidler, J. (1993). Gender differences in mental health service needs among youths entering a juvenile detention center. *Journal of Prison and Jail Health*, 12(2), 73-101.

Dembo, R., Williams L., Wothke, W., Schmeidler, J. & Brown, C.H. (1992). The role of family factors, physical abuse, and sexual victimization experiences in high-risk youths' alcohol and other drug use and delinquency: A longitudinal model. *Violence and Victims*, 7(3), 245-246.

Farrington, D. (1994). Human development and criminal careers. In M. Maquire, R. Morgan & R. Reinger (Eds.), *The Oxford Handbook of Criminology*. New York: Oxford University Press.

Gelsethorpe, L. (1989). *Sexism and the Female Offender*. Aldershot, England: Gower Publishing.

Gilfus, M.E. (1992). From victims to survivors to offenders: Women's routes of entry and immersion into street crime. *Women & Criminal Justice*, 4, 63-90.

Lake, E.S. (1993). An exploration of the violent victim experiences of female offenders. *Violence and Victims*, 8(1), 41-51.

McCormack, A., Janus, M. & Burgess, A. (1986). Runaway youths and sexual victimization: Gender differences in an adolescent runaway population. *Child Abuse and Neglect*, 10, 387-395.

Mouzakitas, C.M. (1981). An inquiry into the problem of child abuse and juvenile delinquency. In R.J. Hunner & Y.E. Walkers (Eds.), *Exploring the Relationship Between Child Abuse and Delinquency*. Montclair, NJ: Allanheld, Osmun.

Phelps, R.J., McIntosh, M., Jesudason, V., Warner, P. & Pohlkamp, J. (1982). Wisconsin Juvenile Female Offender Project. Madison: Youth Policy and Law Center, Wisconsin Council on Juvenile Justice.

Pipher, M. (1994). *Reviving Ophelia: Saving the Selves of Adolescent Girls*. New York: Ballentine Books.

Reich, J.W. & Gutierres, S.E. (1979). Escape/aggression incidence in sexually abused juvenile delinquents. *Criminal Justice and Behavior*, 6, 239-243.

Sanday, P. R. (1996). *A woman scorned: Acquaintance rape on trial*. New York: Doubleday.

Silbert, M.H. & Pines, A.M. (1981). Sexual child abuse as an antecedent to prostitution. *Child Abuse and Neglect*, 5, 407-411.

Sommers, I.S. & Baskin, D.R. (1994). Factors related to female adolescent initiation into violent crime. Youth & Society, 24468-489.

Wells, R. H. (1994). America's delinquent daughters have nowhere to turn for help. *Corrections Compendium*, 19(11), 4-6.

Widom, C.S. (1989). The cycle of violence. *Science*, 244, 160-6.

Wyatt, G.E., Newcomb, M.D. & Riederle, M.H. (1993). *Sexual Abuse and Consensual Sex: Women's Developmental Patterns and Outcomes*. Newbury Park, CA: Sage Publications.

Young, V.D. (1994). Race and gender in the establishment of juvenile institutions: The case of the South. *Prison Journal*, 73(2), 244-265.

OVERREPRESENTATION OF YOUTH OF COLOR IN THE JUVENILE JUSTICE SYSTEM:

Culturally Competent Service System Strategies

It is widely acknowledged by professionals and advocates in the service delivery system that youth of color become involved with the juvenile justice system at rates far exceeding their proportion in the population. For example, in 1993 although 15% of the juvenile population was African American; 28% of all juvenile arrests and 50% of all juvenile violent crime arrests were African American youth (Snyder, 1996). While African American youth are the most consistently overrepresented youth in the juvenile justice system; other youth of color are also overrepresented in that system as well. Significantly, the ethnic/racial group representing the greatest numbers in a particular state, county or city is also the group that is over-represented in the juvenile justice system (Lindsey, 1996) even though their precentage in the population may be relatively small. This is a very serious situation that should not be allowed to continue. Thus, culturally competent approaches to intervention and rehabilitative services must be identifed and implemented if progress in reducing the rate of overrepresentation of youth of color in the juvenile justice system is to be achieved. Cultural competence is defined as a set of congruent behaviors, attitudes, policies and structures that come together in a system, agency or among professionals and enables that system, agency or those professionals to work effectively in the context of cultural differences (Cross, et al, 1989, p. 13).

A meta-analysis of the literature on overrepresentation concluded that two-thirds of existing studies found that racial and ethnic status influenced decisionmakers within the juvenile justice system (Pope & Feyerherm, 1991, Snyder 1996). For example, in a 1990 study by Bishop and Frazier utilizing statewide data over a three year period, the probability of receiving the harshest disposition available was higher for non-Whites than for White youth, even when juvenile offenders were alike in terms of age, gender, seriousness of the offense and prior records. These disparities existed at all levels of the juvenile justice system including petition, secure detention, commitment to an institution and transfers to adult courts (Bishop & Frazier, 1990).

Although national studies have shown that a large majority of juveniles commit delinquent acts, most of these youth are never arrested. One such study conducted in Racine, Wisconsin found that 9 of 10 males and 2 of 3 females who were juveniles in the 1960's and 1970's reported that they had committed at least one illegal act (Snyder, 1996). Nationally, according to Snyder, about 1 of 5 White males and 2 of 5 African American males will be arrested before their 18th birthday. Moreover, on a typical day in 1991, 66% of the youth confined in long-term public juvenile facilities were African American, up from 57% in 1987. Isaacs-Shockley suggests that most juvenile justice systems tend to be culturally biased from the initial assessment through the course of placement disposition and that these systems are inflexible when assessing or serving youth of different racial and cultural orientations.

Of significance is the fact that police officers are gatekeepers with the decisionmaking power to make arrests. If these officers are racially biased, then their decisions are likely to be racially biased as well. This—of course—increases the probability that youth of color will be arrested more often than their White counterparts in similar situations. Gibbs has described African American adolescents as one of the most vulnerable and victimized groups in contemporary American society. They have been: (1) mislabeled and miseducated by the schools; (2) mishandled by the juvenile justice system; (3) mistreated by mental health agencies; and (4) neglected by the social welfare system (Gibbs, 1990).

Bell takes the position that many of the youth who wind up in juvenile justice facilities have serious emotional problems, are extremely stressed out and need mental health services (Bell & Jenkins, 1991; Benjamin, 1995). Indeed, if you are an adolescent and African American and also have a serious emotional disorder, you will probably end up in the juvenile justice system, rather than in the treatment system to which your White counterpart would be referred (Cross, et al, 1989).

Although many states have collected data on overrepresentation in the juvenile justice system, few comprehensive strategies have been developed to significantly reduce the problems of disproportionality (Lindsey, 1996). We do know that a disproportionate number of Hispanic/Latino and African American youth are growing up in poor environments in

which they are exposed to problems such as chronic violence, high unemployment rates, poor housing, inadequate schools, and substance abuse. They are also confronted with such social forces as racism and economic inequity. Conditions such as these increase the probability that these youth will become involved in delinquent behavior. Furthermore, poor, distressed environments provide opportunities for learning about and engaging in delinquent and violent behavior. Some of the characteristics of these environments are the presence of gangs, illegal markets, violent role models, single parent families and high dropout rates. Nevertheless, questions continue regarding whether youth from culturally diverse backgrounds are disproportionately involved with the juvenile justice system: (a) because they commit more offenses; (b) because they are disproportionately impacted by socio-economic factors; (c) because the system is inflexible when serving youth of different racial and cultural orientations; or (d) because there is systematic bias in arrest and adjudication.

The 1993 Coalition for Juvenile Justice annual report identified five principal causes of overrepresentation of children of color in the juvenile justice system: (1) economic, social and cultural issues; (2) subjective decisionmaking in the juvenile justice system; (3) racism in America in general and in the juvenile justice system in particular; (4) cultural, social, ethnic and racial insensitivity; and (5) underrepresentation of persons of color in decisionmaking positions (Coalition, 1993, Lindsey, 1996). Although some attempts have been made to address the issue of overrepresentation through legislative action, these attempts—for the most part— have been unsuccessful. Indeed, an amendment was made to the 1988 Juvenile Justice and Delinquency Prevention Act requiring state plans to include activities for reducing the proportion of juveniles confined in such facilities, if their numbers exceed the proportion these groups represent in the population. It is questionable whether we can "legislate away" the nation's juvenile offending problems (Snyder, 1996).

We do know, however, that positive approaches can be taken to increase the probability that high-risk youth are able to grow up in supportive environments, thus minimizing the probability that they will engage in delinquent behavior. Building a positive base of operation for youth and their families, on the one hand, and linking them with a collaborative service delivery system that is culturally competent, on the other hand, are steps in the right direction.

Strategies for reducing the number of culturally diverse youth in the juvenile justice system should include identifying and putting to constructive use an understanding of the naturally occurring coping mechanisms available to these youth and their families. This could include focusing attention on some of the protective mechanisms that may be available to youth exposed to violence such as: (1) early bonding relationships that promote social development; (2) an adult who can buffer the child from negative influences; (3) experiences that promote positive development; (4) an explicit value system; and (5) promotion of cultural awareness and a positive cultural identity. Those families and communities who are able to promote an active understanding and appreciation of culture as well as a positive cultural identity are able to instill a sense of self-protection and value in their children. This seems to mitigate against youth involvement in violence and juvenile delinquent behavior (Isaacs, 1992).

Fostering skills, status and respect for the individual and building pathways to economic resources are necessary strategies if we are to be successful in addressing issues of overrepresentation in the juvenile justice system. Thus, one important task of public and private youth-serving organizations is to share a common mission of developing supportive environments for healthy growth and development for these youth. Organizations should also use the cultural strengths of these youth in order to re-enforce their cultural identity and integrity. This would provide an opportunity for these youth to move successfully through adolescence and into adulthood without the experience of a long history of involvement in the juvenile justice system. Furthermore, if the juvenile justice system adheres to the five basic elements of a culturally competent system of care, as promoted by Cross et al. the system likely would be in a much better position of begin addressing overrepresentation issues. The five elements of a culturally competent system of care which are also seen as strategies for addressing issues of overrepresentation of youth in the juvenile justice system are: (1) valuing diversity; (2) the capacity for cultural self-assessment; (3) vigilance towards the dynamics that result from cultural difference; (4) the expansion of cultural knowledge; and (5) adaptation to diversity.

Valuing Diversity. In valuing diversity, the system acknowledges that cultural differences exist and is aware of how these differences effect the way in which youth of color are treated by the juvenile justice system. If there is no such acknowledgment or awareness, then it is more likely that decisions are made that may be based upon deeply embedded racial biases and stereotypes. Such attitudes and practices could lead to a situation in

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which a disproportionate amount of the blame is placed on the youth him- or herself, rather than on also looking at ways to "fix" a culturally biased system. By valuing diversity the system takes into consideration its awareness that culture can protect youth against social risk factors by providing a pattern of living—specific values, social support, and affirmation of one's self and one's group.

Cultural Self-Assessment. The juvenile justice system should conduct a self-assessment process to determine if there is a problem with racially disproportionate representation. This should include a systematic monitoring procedure to determine the percentage of youth of color who are being processed at each stage of the juvenile justice system. A detailed evaluation of the criteria used in reaching decisions should be undertaken as well. These steps should be taken by the juvenile justice system with a clear understanding that the system itself has a culture of its own which is reflected in the way the system is structured, the kinds of staff it seeks and the policies and practices it implements.

Dynamics of Difference. Historical discrimination and racism are some of the core underpinnings of the relationship between people of color and the dominant culture (Isaacs-Shockley, et al., 1996). There are consistent and pervasive power differentials within the juvenile justice system especially since those with power (police officers, judges, etc.) are usually dominant culture persons (Isaacs-Shockley, 1994). Because of past experiences within the mainstream culture, youth of color often mistrust the government, its agents and its information (Nickens, 1990). This means that it becomes more difficult to develop effective strategies to address issues of overrepresentation and to make progress in providing treatment and rehabilitation services to youth of color in the juvenile justice system.

Expansion of Cultural Knowledge. Consideration should be given to providing cultural competence training. Workshops should be held which include information about cultural attitudes, values, communication patterns and history. Workshop content should also promote discussion and evaluation of decisionmaking with regard to youth of color in the juvenile justice system.

Adaptation to Diversity. Juvenile justice authorities should consider changing their approach to decisionmaking so as to minimize the chances of making biased decisions. Where disparities in overrepresentation exist, it may be feasible to reconstruct the decisionmaking process to include multiple decisionmakers and to include some decisionmakers with an understanding of the culturally defined needs of the youth involved with the juvenile justice system. To minimize bias in decisionmaking, a guideline-based approach to decisionmaking—geared toward keeping youth from further penetration into the juvenile justice system—should be implemented (Pope & Feyerherm, 1990).

Summary. In addition to adhering to the five basic elements of a culturally competent system of care as a strategy for addressing issues of overrepresentation of youth of color in the juvenile justice system, effective ways to address the root causes of this disparity should also be undertaken by the entire child-serving system and, indeed, by society as a whole. Attention must be focused on such issues as reducing poverty, creating job opportunities for youth and addressing issues of racism and discrimination. Creating opportunities for youth of color to grow up in supportive environments is also seen as a necessary strategy for dealing with issues of overrepresentation in the juvenile justice system. Finally, the juvenile justice system should reconstruct the decisionmaking process to ensure fairness. This should include increasing the numbers of persons of color in decisionmaking positions. Finally, steps should be taken toward the goal of reducing the need for youth of color to become involved in the juvenile justice system in the first place.

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REFERENCES

Bell, C. & Jenkins, E. (1991). Traumatic stress and children. *Journal of Health Care for the Poor and Underserved*, 2(1), 175-188.

Benjamin, M.P. (1995). *Effective Collaboration as the Key to Understanding and Reducing Youth Violence: A Mental Health Perspective*. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

Bishop, D.M. & Frazier, C.E. (1990). *A Study of Race and Juvenile Processing in Florida*. Report submitted to the Florida Supreme Court and Ethnic Bias Study Commission.

Coalition for Juvenile Justice (1994). *Pursuing the Promise: Equal Justice for All Juveniles, 1993 Annual Report*. Washington, DC: Author.

Cross, T.L., Bazron, B.J., Dennis, K.W. & Isaacs, M.R. (1989). *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed* (Vol. 1). Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center.

Gibbs, J.T. (1990). Black American adolescents. In *Children of Color: Psychological Intervention With Minority Youth* (Eds.) Gibbs, J.T. & Huang, L.N. (pp. 179-223). San Francisco, CA: Jossey-Bass Publishers.

Isaacs, Shockley, M. (1994). Cultural competence and the juvenile justice system: Irreconcilable differences?

Focal Point, 8(2), (pp. 19-20). Portland, OR: Research and Training Center on Family Support and Children's Mental Health, Portland State University.

Isaacs-Shockley, M., Cross, T., Bazron, J., Dennis, K., & Benjamin, M. (1996). Framework for a culturally competent system of care. In B.A. Stroul (Ed), *Children's Mental Health: Creating Systems of Care in a Changing Society* (pp. 23–39). Baltimore, MD: Brookes Publishing Company.

Isaacs, M.R. (1992). *Violence: The Impact of Community Violence on African American Children and Families*. Arlington, VA: National Center for Education in Maternal and Child Health.

Lindsey, M.L. (1996). The overrepresentation of ethnic minority youths in the juvenile justice system. *Cultural Diversity Strategies to Reduce Disproportionate Ethnic Minority Confinement in Secure Juvenile Facilities*. Dallas, TX: Nestor Consultants, Inc.

Nickens, U. (1990). Health promotion and disease prevention among minorities. *Health Affairs*, Summer: 133-143.

Pope, C. & Feverherm, W. (1990). *Minorities and the Juvenile Justice System*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

Snyder, H (1996). The juvenile court and delinquency cases. In R.E. Behrman (Ed.), *The Future of Children* (pp. 53-63). Los Altos, CA: Center for the Future of Children. The David and Lucille Packard Foundation.

Snyder, H.N., Sickmund, M. & Poe-Yanmagata, E. (1996). *Juvenile Offenders and Their Victims: 1996 Update on Violence* (pp. 4-15). Pittsburgh: PA: National Center for Juvenile Justice.

PARENTS AT THE FRONT DOOR IN FAMILY COURT AND CHILD WELFARE: DEVELOPING PARENT SUPPORTS IN THE JUVENILE JUSTICE SYSTEM

Imagine you're a parent and your child is arrested and taken to court. Your ears are ringing with legal jargon you do not understand. Suddenly, your child is handcuffed, shackled and sent to the detention center. You are left sitting in the courtroom wondering what just happened.

It wasn't so long ago that this was a typical scene in family court. About ten years ago things began to change in Stark County, Ohio. Caring professionals from Family Court, Mental Health, Human Services, and other systems and agencies with parents came together to do business differently. These public systems worked together to create changes that would eliminate much of the frustration and confusion often felt by families. They developed a collaborative group that met on a regular basis to better coordinate all of the human services and develop the support services that families needed.

In 1993, the Stark County Family Council emerged from these efforts to provide a community infrastructure for all of the child-serving systems in Stark County. It was built upon a cross-system mission statement and guiding principles. Common protocols and processes were also developed so that families received services and supports from all of the county's available resources.

Family Court was there from the beginning. Judge Julie Edwards says that, in fact, not all jurisdictions work well collaboratively. Judge Edwards believes family court judges can and should be supportive of such programs. "Historically, our agencies have been able to talk to one another. From what I understand, other jurisdictions have had turf problems," Judge Edwards said. "We seem to have less serious turf problems than other jurisdictions."

She said that in some jurisdictions, the family courts and the Department of Human Services are just in conflict with each other. "It's almost like a war," she continued. "It's going to take someone to step forward and say 'Gee, we shouldn't have to live like this any more. The idea is to get services to kids. Is there any way we can talk to each other and work this out and still maintain our roles.'"

In terms of Stark County's philosophy, Judge Edwards envisions an increase in the delivery of services within homes so that a child does not have to be removed permanently. "That has been a change in preventative philosophy," Judge Edwards said. "Obviously it doesn't work all of the time. Sometimes we have to come to terms with the fact that endless resources are not available. If a family cannot make improvements, even with all kinds of intensive services, then we have to ask if the removal of the child is the answer. In some cases, with daily wraparound services, families have been able to turn their lives around."

However, Judge Edwards commented that as Stark County's jurisdiction grows in terms of people and number of problems, it becomes more and more difficult to maintain the collaborative process. "I think people ought to be aware that collaboration is a good idea and a necessary idea but, whether you are just starting out or you are trying to maintain an effort, it takes a lot of work."

Family Court Administrator Rick DeHerr recalls the commitment that the systems made to invest in the process for families and children. By listening to families who had received services, it became clear that more supportive services were needed. Families were very good at support-

ing one another. As a result, parent advocates were trained and became an important part of the Creative Community Options process. "It just made sense," DeHerr said, "when all of the service providers and systems worked independently, we were unable to truly help a family."

"But with all of us coming together with the family, we were able to construct a plan that was strengths-based. And it worked. We were all on the same page."

One of the first steps taken was the birth of Creative Community Options (CCOs). Simply put, CCOs are creative planning meetings for families who are experiencing multiple challenges. These planning sessions offer a time when the family and child can meet with advocates, professionals and other supportive people from the community. They often include juvenile court representatives, case managers, therapists, ministers, friends and others who seek positive outcomes for the family and are built on the strengths of all participants.

The CCO provides a vehicle to access a wide array of comprehensive community services and supports that meet the needs of the children and their families. The Team makes a commitment to put the family in the driver's seat. The family is supported in this with services through the Parent Department of the Family Council. Parent advocates are assigned to support families throughout the entire CCO process. They not only help families articulate their needs and wants but help them identify community resources.

Parent advocate Canice Tolin remembers the early development of CCOs. "CCOs were a big step taken by these systems that has involvement with families," Tolin said. "It was also the first time that parent advocates attended the family planning meetings and had a say in what the outcomes would be for the families and their children."

Often, parent advocates would accompany families to court as a part of the CCO plan. "For the longest

Judge Edwards

time, I would sit in the waiting room with the family or in the back of the courtroom just offering support," Canice recalled. "Then finally, after attending court for three months with a particular family and helping the mother through the experience, one of the magistrates asked, 'Mrs. Tolin, what would your recommendations be for this youth and his family?'"

This was a turning point for the court. There was a realization that parent advocates were very beneficial to all. Now, parent advocates are introduced in the courtroom. In the majority of cases, they are asked for their opinion along with the other service providers as to the future outcome of the child and family.

The courts now request that families get involved very early in the case with the Stark County Family Council's Parent Department (now known as FACES). Parole officers and intake officers are calling advocates to ask that they become involved with families before the case goes to court. By connecting the family early to a parent advocate, the family can familiarize themselves with how the court system works and have a clear understanding of what is expected.

"I remember one time when a child was sentenced to the Detention Center. The mother sat there and watched her son be handcuffed and shackled. She was visibly upset and wanted to kiss her son good-bye," Tolin recalled, "The mother was told that she couldn't touch her son as he was now in the custody of the court. That was very hard on her but we were able to explain this to her and offer much needed support."

Parent advocate Carol Hershey is no stranger to the courtroom either. She is both a parent advocate and a guardian ad litem for Family Court. "I am very happy to see parent advocates in the courtroom," Hershey confessed. "If it's the first time in the courts for someone, it can be very intimidating and very scary. Many don't know what an adjudicatory hearing is. It is helpful to have a friend who simply explains the procedure to you."

Hershey continued to explain how fast things happen in a courtroom as well. "It all happens very quickly with a lot of legal terms that parents really don't understand. They used to walk out of court and ask, 'What just happened in there?'"

In some cases, a family may want the child to leave the home for the safety of the other children in the home. "Sometimes it is the second or third time a child had gotten into trouble. The courts have slapped their hands but the parents want the child to be accountable for his or her actions," Hershey explained. "I remember a seventeen-year-old youth who had been arrested for felonies four times. Each time the charges were reduced and he was sent home and put on probation."

"There were a lot of underlying issues that had not come out in court such as drug and gang involvement. The parents reached the point where they didn't feel safe and the younger children in the home didn't feel safe either. A CCO was then court ordered for the child and I then became involved. I met with the family beforehand and leaned what they had been living with for the past three years. The issues came out at the CCO. As a result, the child's extenuating issues were addressed."

The CCO resulted in a drug rehabilitation program, an anger management program, and probation with a tracker to monitor his daily activities. What emerged was a child who became accountable for his actions, gained back his self-esteem and earned a 3.2 grade point average on his next report card.

Currently, the Parent Department has four parent advocates who attend all court sessions and several more advocates are in training. They provide a wide variety of services such as instructing youth on how to behave appropriately and show the proper

respect for the judge before entering a courtroom. Still in other cases, they may explain the importance of the family's case plan and what it entails as well as assisting low-functioning parents on improving their parenting skills.

The overall result in Stark County is that parents no longer find themselves sitting in the courtroom wondering what happened there. By developing parent supports in the family court system, children and families are finding the supports and services they need. The collaboration is working.

But whether you live in a city or a small town, every community is accountable to respond to the changing needs of children and their families. Systems can no longer go about their "business as usual" and continue to work in isolation. The rise of community collaborations has never been more urgent or important.

Stark County's collaborative mission is a work in progress. As the community grows and the needs change, the challenges grow as well. As Judge Edwards said, "Whether you are just starting out or you are trying to maintain an effort, it takes a lot of work." For additional information, please contact the Stark County Family Council: 800 Market Avenue, North, Suite 1600, Canton, Ohio 44702-1075; (330) 455-1225 (voice); (330) 455-2026 (fax).

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THE OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION: A FEDERAL PARTNER IN MEETING THE MENTAL HEALTH NEEDS OF JUVENILE OFFENDERS

These are exciting and challenging times in the development of services for families and youth. Agencies throughout government are making great strides in coordinating their programs with other agencies to support collaboration at the local level; and many state and local jurisdictions are improving their systems of care for children, youth and families. Supporting this climate and creating the opportunity to address the needs of children and youth is a key priority of the Office of Juvenile Justice and Delinquency Prevention (OJJDP), U.S. Department of Justice. One critical aspect of this work focuses on addressing the mental health needs of juvenile offenders. In our efforts to appropriately serve youth in the juvenile justice system who have mental health needs, however, OJJDP, along with state and local systems, are faced with many challenges.

Our first challenge is to gain an accurate picture of the scope and nature of the problem. There is a significant lack of empirical, systematic data on the prevalence of emotional and mental health problems among juvenile offenders. Research to date has been uneven and the quality of the data varies greatly. Often, we must extrapolate information from studies of the prevalence of mental disorders in the general youth population, which has been put as high as 22 percent.

Otto, Greenstein, Johnson, & Friedman's 1992 review of epidemiological studies among juvenile offenders show that between 50 and 90 percent of juvenile offenders have conduct disorders;

- up to 46 percent of juvenile offenders have attention deficit disorders; and
- six to 41 percent of juvenile offenders have anxiety disorders.

Findings from studies also indicate that there is a very high co-morbidity with respect to mental disorders and drug abuse. Evidence indicates that the existence of multiple mental health symptoms among the juvenile offender population is great, especially among youth whose primary diagnosis is conduct disorder.

OJJDP's Conditions of Confinement Study examined detention center and training school administrators' perception of mental health problems among juvenile offenders in their facilities. These administrators indicated, in their assessment of the situation, that:

- 75 percent of the juvenile offenders had significant family problems;
- 44 percent exhibited disruptive behavior;
- 43 per cent demonstrated violence towards others;
- 52 percent showed symptoms of depression; and
- 51 percent appeared to have been abused by their parents.

While the picture is far from complete, it appears that a substantial number of juvenile offenders have mental health needs. Additional research is needed, however, to gain more definitive answers and to guide juvenile justice policy and system improvements.

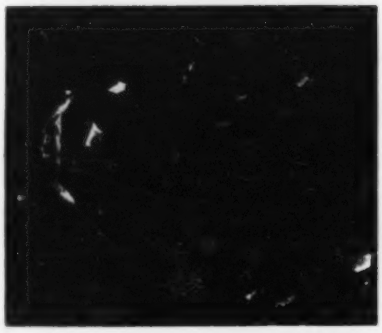
The second challenge confronting the field of mental health, and juvenile justice practitioners and policy makers is the inadequate supply of services available to meet the needs of youth with mental illness. Even in

today's climate of cooperation, youth who are determined to be "mad" and "bad" are inevitably bounced between the mental health, education, child welfare, and juvenile justice systems. The end result is that their needs are not effectively met by any of the systems, resulting in a tremendous cost to society, as well as to the youth and their family—financially, socially, and personally. The juvenile justice system has, in many cases, become the "default system" for the provision of mental health services. This is not, however, a challenge that the juvenile justice system can effectively meet alone—it simply does not have the capacity to do so.

A third challenge results from the changing philosophy about the juvenile justice system during the past two decades. As state legislation moves toward a juvenile justice system more focused on punishment and incapacitation, rather than treatment, local systems are faced with a formidable challenge to intervene with delinquency to prevent its recurrence. In this context, it becomes increasingly difficult to maintain the treatment and skill development of juveniles in the juvenile justice system to facilitate their returning to our communities as law abiding, productive, and healthy citizens.

Finally, managed care presents some new and yet unknown challenges for the juvenile justice and mental health systems. If managed care restricts availability of mental health services, placement facilities in the juvenile justice system could receive substantially more referrals without the benefit of adequate treatment. Once again, the juvenile justice system is not being provided with the resources to assume this additional burden.

There are some positive signs, however, that we will overcome the challenges confronting us. For example, the National Coalition for Mental and Substance Abuse Health Care in the Justice System has been conducting its multi-state policy academies, which appear to be positively impacting youth mental health



policy in several states. Over the past several years, the Child and Adolescent Service System Program helped states make enormous strides in developing systems of care for youth with serious mental, emotional and behavioral disorders.

The Center for Mental Health Services has been making advances by fostering joint Federal examination of mental health services for youth and funding several grant programs to create local systems of care for children, youth and families. It appears that youth in the juvenile justice system will be included in these efforts.

In addition to these beacons of hope, there are local efforts such as those found in Norfolk, Virginia and many other jurisdictions where joint teams of key service providers are conducting assessments and developing comprehensive treatment plans for non-delinquent and delinquent youth. The Norfolk Interagency Consortium (NIC) is governed by a board of representatives from health, social service, law enforcement, education, juvenile justice and other agencies, as well as parents and private citizens. The board ensures coordinated delivery of comprehensive services, including access to a state pool of funds. Service collaboration is put into action by community assessment teams (CATs), which consist of case managers from the agencies represented on the NIC. The CATs conduct needs assessments and treatment plans for children whose multiple, co-occurring problem behaviors require collaboration between more than one discipline or agency. The comprehensive assessments and treatment plans are carried out by the responsible agencies, working closely, under the supervision of the assigned CAT. This type of model holds promise for providing the individualized wrap-around services that juvenile offenders need in order to achieve significant and lasting changes in their lives.

Research findings from the South Carolina Family and Neighborhood Services (FANS) Project have also been impressive. The multi-systemic therapy developed by Scott Henggeler and Charles Bourduin, based on family systems theories, social ecology theory and child development considerations, appears to have a very positive impact on future recidivism of participant youth as compared with control group youth. Based in a community mental health center, the program represents a cooperative effort between the state's Department of Youth Services and Department of Mental Health. FANS attempts to avoid the institutionalization of seriously troubled youth. Youth referred to FANS from the Department of Youth Services are at imminent risk of out-of-home placement because of the seriousness of their offense histories. They average 3.5 previous arrests and 9.5 weeks of previous incarceration. Over half have at least one arrest for a violent crime, including manslaughter, assault with intent to kill, and aggravated assault.

The project was evaluated in 1992 using a random-assignment design that compared program participants with youth who received the regular services provided by the Department of Youth Services. The evaluation findings were very encouraging. Fifty-nine weeks after the initial referral, FANS participants had slightly more than half as many arrests as the usual services control youth: 68 percent of control youth experienced some incarceration compared with 20 percent of the FANS group, and 58 percent of FANS youth had no arrests compared with 38 percent of control youth. These findings were reinforced by self-report measures and by favorable changes among the FANS group re-

garding family cohesion and reduced aggression with peers. In addition, even given the intensity of the intervention, costs were relatively low, averaging $2,800 per client for a period of several months, compared with more than $16,000 for the usual course of institutionalization in South Carolina.

OJJDP is supporting and advancing these positive efforts and facing the challenges described above through our demonstration, training and technical assistance efforts, and information dissemination.

OJJDP's approach to the multi-service needs of delinquent youth and the communities needs for protection is found in its **Comprehensive Strategy for Serious, Violent and Chronic Juvenile Offenders**. The strategy offers a set of key organizing principles:

(1) we must strengthen the family in its primary responsibility to instill moral values and provide guidance and support to children;

(2) we must support core social institutions—schools, religious institutions, and community organizations—in their roles of developing capable, mature, and responsible youth;

(3) we must promote delinquency prevention as the most cost-effective approach to reducing juvenile delinquency;

(4) we must intervene immediately and effectively when delinquent behavior occurs to successfully prevent delinquent offenders from becoming chronic offenders or progressively committing more serious and violent crimes; and

(5) we must identify and control the small group of serious, violent, and chronic juvenile offenders who have committed felony offenses or have failed to respond to intervention and nonsecure, community-based treatment and rehabilitation services offered by the juvenile justice system.

The Comprehensive Strategy also emphasizes the integration of services and the need for services to collaborate in supporting young people. It recognizes that "comprehensive approaches to delinquency prevention and intervention will require collaborative efforts between the juvenile justice system and other service provision systems, including mental health, health, child welfare and education." Developing mechanisms that effectively link these different service providers at the program level is a critical component of every community's comprehensive plan.

To demonstrate the Comprehensive Strategy, OJJDP developed and is funding the **SafeFutures Program**. This project has pooled resources available under Title II, Parts C, D, and G, and Title V of the Juvenile Justice and Delinquency Prevention Act of 1974, as amended, to provide approximately $1.4 million per year to six jurisdictions (St. Louis, MO; Contra Costa County, CA; Imperial County, CA; Boston, MA; and Fort Belknap, MT). These communities are being funded to implement a balanced system of services, supports, and sanctions for juveniles. As part of this major initiative, each site has been allocated $150,000 per year to begin to address some of the mental health issues within their juvenile justice system through plans for the development of a mobile mental health unit that will bring services directly to at-risk and delinquent youth; the provision of mental health consultation and liaison services to police, juvenile court judges, district attorneys, and correctional staff; and ensuring that individual treatment plans developed for youth are culturally competent, with provisions for active family participation.

In addition to being included as a stand alone component in the SafeFutures program, mental health issues are interwoven throughout the program and form an integral part of many of the other components. Examples include the emphasis on providing case management; mental health services in the components addressing serious, violent, and chronic offenders; at-risk and delinquent girls; and family strengthening. The key to this project is the integration of services and commitment to common objectives by multiple disciplines, to improve outcomes for children with mental health needs.

OJJDP is also addressing mental health issues through Part E, State Challenge activities of the Juvenile Justice and Delinquency Prevention Act, as amended in 1994. The purpose of the **State Challenge Activities** is to provide incentives for states participating in the Formula Grants Program to develop, adopt, and improve policies and programs in one or more of the ten specified Challenge areas. Four of the State Challenge activities emphasize mental health issues:

Challenge Activity A requires recipients to develop and adopt policies and programs to provide basic health, mental health, and appropriate education services, including special education, for youth in the juvenile justice system. In fiscal year 1995, the first year of funding for this program, fifteen states applied for and received monies to tackle this challenge.

Challenge Activity E focuses on implementing programs that address the needs of female juvenile offenders, including their mental health needs. Twenty-three states accepted this challenge.

Challenge Activity I addresses the need to establish effective aftercare services for juvenile offenders, including the provision of comprehensive mental health services. Nineteen states are currently receiving funding to engage in this activity.

Challenge Activity J funds states to establish a state administrative structure, comprised of representation from the major child-serving systems, to coordinate programs and fiscal policies for juvenile offenders with emotional and behavioral problems and their families. It also addresses the need for a statewide case review system for this particular group. In Fiscal Year 1995, three states applied for and received funding to meet this challenge activity.

It is also the policy of OJJDP to make every effort to integrate our programs with those of other agencies that are serving at-risk and delinquent youth. In that regard, we have been

working with the Department of Health and Human Services Administration on Children, Families and Youth to coordinate our programs, particularly our **Title V Community Prevention Grants**, with their family preservation efforts. We are also working closely with the Center for Mental Health Services to support their **partnerships with Native American communities fostering systems of care**. In addition, OJJDP has been involved with the Indian Health Service, through its Albuquerque office, to coordinate their services with the four Indian tribes OJJDP is funding under the **Native American Alternatives to Incarceration Program**. We also participated as a co-sponsor of the **National Invitational Conference on "Making Collaboration Work for Children, Youth, Families, Schools, and Communities."**

CALL FOR PAPERS

The Federation of Families for Children's Mental Health's ninth annual conference is scheduled for November 20-23, 1997 at the J.W. Marriott Hotel in Washington, D.C. Cornel West, author of *Race Matters*, will be a featured keynote speaker. Workshop proposals featuring innovations in the following areas are invited: family involvement in developing and evaluating systems of care (including managed care); effective juvenile justice, education, and mental health initiatives; advocacy partnerships between families and professionals; state and national level legislative advocacy; preparing families for the impact of welfare reform; youth involvement in developing and evaluating systems that care for them; and assuring cultural and racial competence in developing and evaluating systems of care.

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which focused on youth with serious emotional disorders; and are coordinating with the Department of Agriculture, the White House Domestic Policy Council, the President's Crime Prevention Council and the Coordinating Council on Juvenile Justice and Delinquency Prevention to focus on juveniles' mental health issues.

In fiscal year 1997, OJJDP is proposing in its Program Plan to transfer funds to the National Institute of Mental Health, along with the Centers for Disease Control and Prevention and the National Institute on Drug Abuse, to support the **Risk Reduction Via Promotion of Youth Development Program**. The Risk reduction program consists of a large-scale prevention trial involving hundreds of children and several elementary schools located in lower socioeconomic neighborhoods of Columbia, South Carolina. The trial is designed to promote coping-competence and reduce risk for conduct problems, substance use, and school failure beginning in early elementary school.

Finally, OJJDP is also proposing a **Mental Health/Juvenile Justice Initiative** which will provide support in one or more of the following areas: (1) assessing screening instruments and procedures to identify multi-needs children, adjudicative competency, and other mental health issues; (2) examining how organizations provide mental health services on both a short-term and long-term basis; (3) examining the relationship between mental health and violence and co-occurring disorders; and (4) looking at best practices, such as the use of common funding streams.

Clearly, meeting the needs of juvenile offenders with mental illness has been and continues to be at the forefront of OJJDP policies and practices. While these efforts are significant, more needs to be done at the federal, state and local levels to ensure that the juvenile justice, mental health, child welfare, and education systems are working together to effectively serve juvenile offenders with mental illness. Federal, state and local agencies must develop a shared vision, a clear definition of the problem, sound principles of intervention, and a comprehensive plan of action to address the mental health needs of juvenile offenders. Agencies can no longer continue to operate in isolation from each other, speaking in different languages, and having radically different eligibility criteria. We must encourage collaboration and coordination of services across agencies, joint planning, pooled resources, and shared training. This is the difficult work OJJDP is committed to and, together with our partners, we will make a difference.

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REFERENCES

Henggeler, S., et al. (1992). Family preservation using multisystemic therapy: An effective alternative to incarcerating serious juvenile offenders." *Journal of Consulting and Clinical Psychology* 60(6), 148-149.

Howell, J.C., ed. (1995, May). *Guide for Implementing the Comprehensive Strategy for Serious, Violent, and Chronic Juvenile Offenders*. Washington, D.C.: Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice.

Parent, D. et al. (1994, August). *Conditions of Confinement: Juvenile Detention and Correction Facilities: Research Report*. Washington D.C.: Office of Juvenile Justice and delinquency Prevention, U.S. Department of Justice.

Otto, R.K., Greenstein, J.G., Johnson, M.K., and Friedman, R.M. (1992). Prevalence of mental disorders in the juvenile justice system. In J.J. Cocozza (Ed.), *Responding to Youth with Mental Disorders in the Juvenile Justice System*. Seattle, WA: The National Coalition for the Mentally Ill in the Criminal Justice System.

Wilson, J.J., and J.C. Howell. (1993). *Comprehensive Strategy for Serious, Violent, and Chronic Juvenile Offenders: Program Summary*. Washington D.C.: Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice.

YOUTH WITH DISABILITIES IN THE JUSTICE SYSTEM: INTEGRATING DISABILITY SPECIFIC APPROACHES

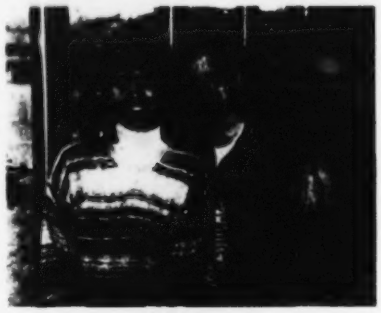
YOUTHFUL CRIMINAL BEHAVIOR

Despite a recent decline in crime, juvenile criminal behavior has been a subject of some concern for the past decade (Earls, 1994; Blumstein, 1995). Approaches to addressing the problem have been costly and their effectiveness remains controversial (Pioneer Press, 1997); U.S. News, 1997). Parents, juvenile justice professionals, policymakers and youth advocates struggle with the challenge of determining which consequences are most effective in preventing crime and recidivism among our youth.

JUVENILE OFFENDERS WITH DISABILITIES

The reasons for youthful criminal behavior are complex. However, there is some agreement that youth who become involved in the juvenile justice system may do so because of the interaction of multiple factors. School failure is one risk factor consistently associated with delinquency, violence and other illegal behaviors (Earls, 1994; Ingersoll, 1997; Greenwood, 1996). Often, school failure is associated with emotional and behavioral disorders (EBD) and learning disabilities (LD) that have not been identified, have been misidentified, or have not been effectively addressed. Increasingly, schools, "as a last resort" are reporting students with EBD whom they consider to be unmanageable to law enforcement and are pressing criminal charges for aggressive behaviors in the schools. Legal advocates argue that often these behaviors are not always criminal or dangerous, and that, in many cases, these behaviors reflect the frustration of youth with disabilities who have not benefited from special education and related services to which they are entitled (Boundy, 1997).

Among offenders, the most prevalent disabilities are EBD, LD, conduct disorder (CD), attention deficit/hyperactive Disorder (ADD/HD), Developmental Disabilities (DD) and depression. Often, more than one disability may coexist. Depending on the disability, the range of characteristics can include impulsivity, delayed social skills, defiance, poor judgment, low self-esteem, impaired decision-making, and risk-taking behaviors. These characteristics may also be associated with involvement in delinquent and illegal behaviors.



In one comprehensive survey of behavioral disorders among youth in juvenile correctional facilities, the incidence of ADD/HD, for example, was 46 percent (Otto, 1992). The author went on to speculate, however, that the prevalence may be even higher. Considering that the incidence of ADD/HD within the general population is approximately 3 to 5 percent (Barkley, 1997), the discrepancy is significant. The disparity is evident in other disabilities such as DD and LD (Otto, 1992). Other sources also suggest a connection between the presence of a disability, school failure, and subsequent criminal behavior. Data from a longitudinal survey of students with disabilities showed that youth with disabilities were less likely to graduate and that, irrespective of the type of disability, those students who dropped out of school were more likely to be arrested than those who remained in school (Wagner, 1992). Among those identified as having a serious emotional disorder, who dropped out of school, 73 percent were arrested within five years. The same study documented that 31 percent of youth with LD were arrested within three to five years of leaving school

SERVICES MANDATED BY FEDERAL LAW

Youth who qualify for special education services under the Individuals With Disabilities Education Act (IDEA) or Section 504 of the Rehabilitation Act are entitled to these same services in a corrections setting. State departments of correction and the school districts in which they are located provide special education services to adjudicated youth. As in typical school settings, parents retain their rights to participate in the writing of their youth's Individualized Education Program (IEP)—through age 21—while the youth is in a correctional program. Transfer to a correctional setting such as a residential facility, boot camp, ranch, or adult facility is considered to be a change in educational placement and, therefore, according to IDEA, is subject to the same review and provisions as any other change in school would entail.

THE NEED FOR DISABILITY-SPECIFIC APPROACHES

The presence of a disability does not excuse a youth from responsibility or consequences for delinquent or illegal behaviors. The juvenile justice system, however, must continually balance the need for public safety with the provision of rehabilitative consequences for the offender.

Given the knowledge that a significant proportion of young offenders have disabilities, information and disability characteristics and effective approaches is critical when choosing appropriate settings and determining consequences. In order to make adjudication and placement decisions, a judge, public defender, dispositional advisor, probation officer, and other corrections staff need to consider the following:

- Is there a possibility that, because of a disability, this youth does not understand the charges?
- Has the youth received special education services in his or her previous school placement? Is there a current IEP?
- Is an updated or more comprehensive disability or mental health evaluation needed?
- Does the correctional setting being considered for this youth have programs than can accommodate and specifically address his or her disability?
- Are the needs addressed in the youth's IEP considered and integrated into the consequences determined by the court?
- Does the youth have some understanding about the disability and a plan to address his or her risk-taking or illegal behaviors?
- Do parents (guardians, foster parents or surrogates), education professionals, correctional program staff, employers and others involved with the youth understand the youth's disability needs? What can they do, collaboratively, to provide the youth with supports to successfully transition back into the community, including an aftercare program?
- Are teachers or employers being provided with assistance and knowledge about the range of options they need to address this youth's disabilities or problematic behaviors?

If there is no documentation of a disability and the youth or family has not indicated a prior diagnosis, the following questions are also pertinent:

- Are there aspects of the youth's behavior that warrant a screening for a disability evaluation?
- Has the youth experienced a history of behavioral or learning problems?
- How, if at all, have these issues been addressed by the family or the school?

PACER CENTER'S PROJECT ON YOUTH WITH DISABILITIES IN THE JUSTICE SYSTEM

In 1994, PACER Center, a parent training and resource center in Minneapolis, initiated an innovative national pilot project focusing on the needs of youth with disabilities in the juvenile justice system. PACER advocates were responding to an increasing number of requests for assistance from parents and professionals in regard to special education services for youth in correctional settings.

Through this project, training and resources have been developed on the unique needs of this population and how those needs can be addressed in the juvenile justice system and corrections settings. Topics include:

- Characteristics of those disabilities most common among juvenile offenders;
- Unique risks for illegal behaviors among youth with disabilities;
- Special education entitlements for juvenile offenders in correctional programs;
- Issues related to identifying and integrating disability-specific considerations in correctional responses and programming; and
- Strategies to support juvenile offenders and their families in aftercare to facilitate successful transitions from correctional settings to the community.

The project is hosting a national three-day Training-of-Trainers Institute this Fall to promote replication of the training model. The institute will be September 22, 23, and 24 in Minneapolis. For more information about the project or to apply to the training institute contact Lili Frank Garfinkel, Project Specialist, at (612) 827-2966. PACER's web site is www.pacer.org

THE SIGNIFICANCE OF A DISABILITY FOR YOUTH ACCUSED OF AN OFFENSE

A youth's disability may interfere with his or her capacity to understand what constitutes criminal behavior, to understand interrogation questions, and to respond meaningfully and appropriately in the justice process. For example, a youth with LD or DD may admit to a crime he or she did not commit because he or she did not understand the questions asked, or may provide an answer that he or she believes will please the investigator or person in authority. Youth with disabilities may waive their rights to counsel because they do not understand what it means to do so, or they may believe this action implies they are innocent. Insufficient knowledge of a disability and its characteristics may result in professionals misinterpreting behaviors such as anxiety, fidgeting, or other involuntary movements as signs of guilt. A youth with emotional and behavioral problems may seem to be acting rudely or aggressively when, in reality, the behaviors reflect fear and anxiety. Because of a disability, he or she may not express these feelings in typical ways.

EFFECTIVE APPROACHES FOR OFFENDERS

Currently, some of the approaches that are thought to hold promise for juvenile offenders include those that identify and promote vocational, social, and functional skills, stress self-awareness, integrate restorative justice concepts such as accountability and restitution, include a comprehensive and well-supervised aftercare component, and reach out to family members, the school, peers, and members of the community in developing coordinated intervention efforts. The next step is to evaluate these strategies specifically for youth with disabilities and, where necessary, make adaptations that meet their disability needs. For example, youth with DD need to prac-

tice strategies repeatedly to avoid choosing risky behaviors; children with ADD/HD need immediate consequences for problematic behaviors. For some youth the presence of a disability is closely tied to their difficulties with developing social and life skills, self-control, and competencies. As a result, they may have a unique risk for greater involvement in illegal behaviors. With interventions more closely tied to addressing these needs, it may be possible to reduce these risks.

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REFERENCES

Barkley, R. (February, 1997). Workshop on Attention Deficit Hyperactivity Disorder. Minneapolis, MN.

Blumstein, A. (August, 1995). *Violence by Young People: Why the Deadly Nexus?* National Institute of Justice.

Boundy, K. (April 11, 1997. *Policy Statement*. Boston: Center for Law and Education.

Butterfield, F. (April 16, 1997). Study Finds Fault With Popular Anti-Crime Icons. *St. Paul Pioneer Press*.

Earls, F. (Winter 1994). Violence and Today's Youth. *The Future of Children*, 4:3.

Gest, T. (April 21, 1997). A Taxpayer's Guide to Crime and Punishment: A New Study Shows What Strategies Work. *U.S. News and World Report*.

Greenwood, P., Model, K., Rydell, C. & Chiesa, J. (1996). *Diverting Children From a Life of Crime: Measuring Costs and Benefits*. Santa Monica, CA: RAND.

Ingersoll, S. & LeBoeuf, D. (February, 1997). Reaching Out to Youth Out of the Education Mainstream. In *Juvenile Justice Bulletin*. Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice.

Otto, R. (1992). In J.J. Cocozza (Ed.), *Responding to the Mental Health Needs of Youth in the Juvenile Justice System*. National Coalition for the Mentally Ill in the Criminal Justice System, 8-28.

Wagner, M. (December, 1992). *What Happens Next? Trends in Postschool Outcomes of Youth With Disabilities*. Office of Special Education Programs, U.S. Department of Education.

MULTISYSTEMIC THERAPY: AN EFFECTIVE COMMUNITY-BASED ALTERNATIVE TO INCARCERATION

Sixty years of research on traditional mental health and juvenile justice services for juvenile offenders has shown that these services have little effect on reducing rates of reoffending. In general, mental health treatments focus on the individual youth, trying to give him or her better social skills, teaching anger management, or providing insight into his or her life circumstances. When families are involved, parents are usually seen as the cause of the problem, and treatment generally aims at improving family communication skills and parental discipline practices.

With a mandate to "protect the public" as well as to rehabilitate, juvenile justice services often take a somewhat different approach than mental health. Increasingly, juvenile offenders are being removed from their families and communities and placed in residential settings such as boot camps and youth prisons where they spend their days and months with other youth who have been engaging in serious antisocial behavior. On the low end, these facilities cost about $40,000 per year, per child; while on the high end—treating juvenile sexual offenders for example—the cost can approach $200,000 per year, per child. While these resources are being spent on housing the youth with other problem adolescents, virtually no resources are devoted to addressing the needs of the family to whom the youth will be returning.

THREE REASONS WHY TRADITIONAL MENTAL HEALTH AND JUVENILE JUSTICE SERVICES DO NOT WORK

Although we know the factors that contribute to delinquency, existing services do not address these factors. A vast amount of excellent research has shown that delinquency is associated with *key characteristics of the youth* (e.g., drug use, low verbal skills), *family* (e.g., ineffective discipline, low warmth, parental difficulties such as drug use, psychiatric conditions, and criminality), *peer relations* (e.g., association with deviant peers), school (e.g., low achievement and dropout, aspects of the schools such as weak structure and chaotic environment), and *neighborhood* (e.g., criminal subculture). Yet, the vast majority of mental health treatment approaches focus on only one or two of these characteristics. If delinquency is caused by a multitude of factors, how can we expect effectiveness from treatments that only focus on one or two factors?

Worse, the interventions of the juvenile justice system may do more harm than good. One of the most consistent research findings is that the strongest single predictor of criminal behavior in adolescents is association with deviant peers. Based on this finding, the last thing one wants to do in treating delinquency is to place these youth together, especially for an extended period of time. Moreover, solid research findings have shown that group therapy with delinquents leads to more criminal activity rather than less.

Mental health and juvenile justice systems provide services that have little to do with the functioning of youth in the real world. De-

linquents and their families usually have very real problems at home, in school, and in their neighborhoods. Yet, mental health services typically attempt to "fix" these problems by talking with the youth in an office for 50 minutes per week. More restrictive services such as incarceration and residential treatment attempt to address these same problems by removing youth from their home, school and neighborhood, and providing services in some distant location. Then the youth is returned to the exact same home, school and neighborhood where little has been done to prepare for his or her return. Even if the out-of-home placement did provide useful interventions, it is unreasonable to expect changes to be maintained if the youth's environment has not been altered to support such change.

Mental health providers and juvenile justice agencies have low accountability for youth outcome. Historically, mental health therapists have distanced themselves from serving delinquent youth and their families. Such distancing has been accomplished by making services relatively inaccessible to families, taking a family blaming attitude, and labeling a lack of therapeutic progress as "family resistance. Likewise, funding for prisons, boot camps, etc. is on the rise, with absolutely no evidence that these interventions decrease criminal behavior.

WHEN THESE THREE REASONS ARE ADDRESSED, FAMILY-BASED TREATMENT CAN REDUCE RATES OF RE-OFFENDING

During the past 20 years, my colleagues and I have been developing and testing, with support from the National Institutes of Health and the Center for Mental Health Services, an intensive home- and family-based treatment for serious antisocial behavior in adolescents and their families. This treatment, called "multisystemic therapy" or "MST" for short, has proven effective in rigorous scientific studies with violent and chronic juvenile offenders in several states.

In South Carolina, for example, in comparison with usual juvenile justice services, MST improved the family relations and peer relations of violent and chronic juvenile offenders who were at imminent risk of incarceration. Importantly, MST also substantially reduced criminal activity over two and one-half years following treatment and reduced rates of incarceration. The reduced rates of incarceration led to a considerable cost savings for MST. Thus, MST reduced crime while saving money and keeping youth in their families and communities.

In Missouri, in a project directed by Dr. Charles Borduin at the University of Missouri-Columbia, the effectiveness of MST was compared with individual outpatient counseling with chronic juvenile offenders and their families. Here, MST was highly effective at improving family relations at decreasing the psychiatric symptoms of family members. Most significantly, at a four-year follow-up, MST was shown to reduce rates of violent offending, other criminal offending, and drug-related offending. Even when a youth in the MST condition did reoffend, it was usually for a less serious offense than counterparts who had received individual counseling.

The success of these research projects has led to many additional projects and changes in state policy. First, we are currently conducting research projects of MST as a family-based alternative to emergency psychiatric hospitalization and residential treatment. Other projects are examining MST with drug abusing and dependent delinquents and with drug abusing young parents of infants and toddlers. Second, the Family Services Research Center has helped to rewrite several Medicaid standards in South Carolina to emphasize family collaboration in services, provider accountability for outcome, and strong MST-based training for provider organizations. Third, MST-based treatment and training projects have been developed in nine states outside South Carolina and Missouri, and numerous other sites are on a waiting list for such development.

WHAT ARE THE KEYS TO MST'S SUCCESS?

1. **Although family problems can certainly contribute to delinquent behavior, parents are seen as the solution rather than as the problem. MST recognizes that therapists come and go, while parents have a 24-hours-a-day, lifelong commitment to their children.** Thus, if we are truly interested in accomplishing lasting improvements in youth functioning, it is absolutely critical that at least one parent figure have the skills and resources needed to effectively nurture and guide a strong-willed and occasionally obnoxious adolescent. Thus, MST therapists devote most of their energies to empowering parents by using identified strengths to develop viable nature support systems (extended family, neighbors, friends, church members) and remove barriers (e.g., parental drug abuse, high stress, poor relationships with mate) to their capacity to function effectively as parents. This entire process is viewed as a strength-focused collaboration between the family and therapist, with the family taking the lead in setting the treatment goals and the therapist taking the lead in suggesting the mechanisms to accomplish these goals.

2. **MST directly addresses the multiple factors that contribute to delinquency.** Once empowered, the MST therapist consults with the parents on the best strategies to—for example—set and enforce curfew and other rules within the home, disengage the adolescent from deviant peers and promote friendships with prosocial peers; improve the

adolescent's academic and vocational performance, and cope with the criminal subculture that may pervade the neighborhood.

3. **MST reduces barriers to treatment access by providing services where the problems occur, in homes, schools and neighborhoods.** MST typically uses the family preservation model of service delivery, where therapists have small caseloads; are available 24 hours a day, 7 days a week; and services are provided in the natural environment of the family at times that are convenient.

4. **MST emphasizes provider accountability for engaging families in the treatment process and for obtaining outcomes.** Families are not blamed for failing to attain treatment goals. Rather, the therapists, supervisors, and administrators are trained to identify barriers to family engagement in the treatment process (e.g., mistrust of mental health professionals, a 70 hour work week) and to achieving treatment goals.

5. **MST is an extremely complex treatment model, and there are numerous therapist, agency, and system-level barriers to the effective use of MST.** MST projects are not easy to start, and it is often very difficult for organizations to maintain the quality of MST services that is needed to achieve the intended outcomes. Thus, training in MST involves an extensive quality assurance protocol. When this protocol is not followed, outcomes deteriorate.

CONCLUSION

Although traditional mental health and juvenile justice services have not been effective at reducing the criminal behavior of delinquents, there are good reasons why this has been the case. When a family-based treatment intensively addresses the known causes of delinquency directly in the home, school and community environment, criminal behavior can be reduced and families can be preserved at less cost than current mental health and juvenile justice approaches.

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"INTENSIVE AFTERCARE" IN JUVENILE CORRECTIONS— THE COLORADO EXPERIENCE

Two years ago, when "Dusty" (not his real name) was sentenced to Colorado's Division of Juvenile Corrections, his future was dim. Assessed as "high risk," and requiring placement in a long term secure residential program, he was grouped with those least likely to succeed and most likely to reoffend. Today, as one of the first graduates of the Intensive Aftercare Program (IAP), Dusty has become a high achiever who has already beaten the odds against him.

Dusty's criminal history included arrests and repetitive adjudications for delinquent acts ranging from theft to sexual assault. His first adjudication at age 13, combined with substance abuse treatment needs, prior out-of-home placement, and single-parent family added up to a risk-of-reoffense profile that spells trouble for corrections professionals. In many cases, juveniles with similar histories spend two or more years in secure correctional facilities, and there is a probability that they will reoffend, be arrested and convicted within a few months of release. Why did Dusty beat these odds? Our agency hopes that the answer is a new program called "Intensive Aftercare."

Incarcerated, multi-problem juveniles arguably present the most challenging population for rehabilitation and transition to prosocial roles in our communities. In Colorado, the population assessed as being the highest risk-of-reoffense group had a recidivism (felony conviction within one year of release) rate of 70% prior to the implementation of the Colorado Intensive Aftercare Program.

This strong probability of future criminal activity by "high risk" juvenile delinquents forces the question of how public funds are spent in juvenile corrections. If reoffense is so likely, why should such juveniles be treated and released in conventional ways? The premise of the Intensive Aftercare Program is that high-risk juveniles require specialized strategies for treatment and phased transitional release. In this way the juvenile corrections system can responsibly address public safety and rehabilitation issues.

Colorado's Division of Youth Corrections is sponsoring a site for experimental implementation of the Intensive Aftercare Program, funded by the federal Office of Juvenile Justice and Delinquency Prevention (OJJDP). The Intensive Aftercare Program is a model program developed by social researchers Dr. Troy Armstrong and Dr. David Altschuler. In the early 1980s Armstrong and Altschuler began a study of juvenile correctional transition practices around the country, later compiling research and theoretical work to create the IAP model in response to an OJJDP initiative. Eight states received training in 1992, and four sites were selected for pilot funding in 1994.

Colorado, Nevada, Virginia, and New Jersey are the four states selected for the federal initiative. OJJDP is funding experimental implementation over a three-year period that began in 1995. A separate initiative provided funding for independent evaluation research. The National Council of Crime and Delinquency (NCCD) is conducting the research

on the project at all four states. It is hoped that the research period will be extended to allow for full implementation and follow-up data collection. The research design tracks services provided and the progress of both experimental and control youths.

The basic strategies of the IAP model (Altschuler & Armstrong, 1994) are:

1. **Preparing youth for progressively increased responsibility and freedom in the community;**
2. **Facilitating youth-community interaction and involvement;**
3. **Working with both the offender and targeted community support systems (e.g. families, peers, schools, employers) on qualities needed for constructive interaction and the youth's successful community adjustment;**
4. **Developing new resources and supports where needed; and**
5. **Monitoring and testing the youth and the community on their ability to deal with each other productively.**

To effect these strategies, an overarching case management system must be put in place to include:

1. **Assessment, classification, and selection criteria;**
2. **Individual case planning incorporating a family and community perspective;**
3. **A mix of intensive surveillance and services;**
4. **A balance of incentives and graduated consequences coupled with the imposition of realistic, enforceable conditions; and**
5. **Service brokerage with community resources and linkage with social networks.**

The Intensive Aftercare model requires several organizational features that were already part of Colorado's system. Standardized and validated assessment systems are necessary in order to sort out which individuals are most likely to reoffend and therefore have the most to gain from intensive interventions. Colorado had

one of the first risk assessment instruments to be validated through a study of outcomes over several years of application. Risk and needs assessments and various forms of standardized testing are performed on all committed youths in Colorado. Case management that bridges from assessment to institutional care, and on through community transition and parole supervision is also a critical ingredient of the IAP formula. Colorado Division of Youth Corrections "client managers" are assigned cases at the time of commitment and retain case planning and supervision responsibilities through parole and discharge.

Lookout Mountain School, a state-operated facility in Golden, Colorado was selected as the site of study due to its proximity to the Denver metropolitan area and the types of juveniles placed there. Lookout Mountain is a secure, long-term residential treatment facility that accepts many of the highest risk and highest needs juveniles in the state's system. IAP researchers wanted to work with an agency willing to experiment in treatment strategies and provide specialized programming for a selected population of individuals. Because Lookout Mountain is close to the metropolitan area, it is easily accessible for visits from families, community-based agencies, and other community representatives. To separate the IAP participants from other youths, the Cedar Unit was selected as the living unit for IAP youths.

The first stage of project planning involved top state officials in designing procedures and practices to adapt the program design to the Colorado site. A management group consisting of a program coordinator, two full-time IAP case managers, the Division of Youth Corrections Research Director, Lookout Mountain administrators, and Division of Youth Corrections regional directors began regular meetings to develop and implement the Colorado project.

The Youth Corrections research office collected recidivism data for a cohort of youths who had been placed at Lookout Mountain during a three year period prior to the beginning of the IAP project. All of these juveniles had serious or chronic delinquent histories prior to placement at Lookout Mountain. Overall, about thirty-nine percent of these youths had a new felony conviction within one year following sentence expiration. Through the statistical method of regression analysis several variables were identified as being highly correlated with reoffense within this group. These items included young age at time of first adjudication, number of out-of-home placements, and living situation at time of commitment (single parent family weighed as the strongest risk factor). The third of the full group with the strongest risk characteristics in these areas had an average reoffense rate of 70%. A special risk assessment instrument was developed using these variables, and all youths referred to Lookout Mountain were given an "IAP risk score" by assessment clinicians at the time of referral. When juveniles were identified as "high-risk" on the IAP instrument, they were then randomized at NCCD (the IAP national research agency). "Experimental" subjects were assigned to one of the IAP client managers and placed into Cedar Cottage at Lookout Mountain. The "control" subjects were assigned to regular client managers and assigned to units other than Cedar. After finding that a number of youths with chronic psychiatric hospitalization histories were falling into the project pool, it was decided that the risk instrument would screen out such youths from consideration in the project.

It was agreed that IAP client man-

agers would be limited to a maximum of 18 clients, with no more than 12 in the community at any time. This caseload is less than half of what other client managers are currently assigned. Two seasoned client managers volunteered for the special project duty. These individuals were given assignments in the general implementation and management of the program as well as case management tasks. The initial project was the development of standards and guidelines for program operations that would ensure implementation of the IAP model and maximum opportunity for effective interventions to the high-risk experimental group. Under the direction of the management team, a "service providers group" was formed, composed of representatives of Lookout Mountain, community-based residential and non-residential providers, and the client managers. This group took on the work of brainstorming intervention strategies to best implement the IAP model in Colorado.

The IAP researchers, primarily Troy Armstrong, provided technical assistance throughout each stage of implementation. The most challenging aspects in Colorado were the development of youth incentives, and implementing the experimental design. When the service provider group began to list creative treatment plans and sanctions, tremendous energy was unleashed within this group of talented and experienced treatment specialists. Private, community-based providers were very pleased to be asked to contribute ideas about case management and treatment in the state's correctional system, and institutional staff were likewise excited by having an opportunity to help design transition strategies. With little encouragement, the service provider group hammered out plans for "backing in" services to Lookout Mountain, and improving and linking treatment modalities. Development of a continuum of sanctions, from "progress staffings" to regression to secure placements came easily to the service provider group, because they shared a common background in community-based corrections approaches to transition. When asked to list "incentives," however, they struggled. Dr. Armstrong suggested that at least three incentives should be listed for each sanction. This goal, combined with hands-on experience talking with clients about what would motivate them, moved the creative process along rapidly.

The most difficult implementation challenge has been in maintaining the experimental design. Like any other human service professionals, correctional workers want to provide the most innovative, highest quality services to all clients. Many roadblocks were encountered involving the need to distinguish the experience of the IAP clients from the control group. The management team intervened in a number of issues to ensure adequate separation and differential treatment that could allow the experimental design to work without compromising the correctional ethics of the agency. Strong support from the highest levels of the Division of Youth Corrections has motivated all the participants to find ways to see through the commitment that the agency had made to this important initiative.

"Dusty," the client mentioned above, was one of the first individuals identified in the experimental group. His client manager had the unique opportunity of working with his younger brother, who was sentenced to Youth Corrections shortly after Dusty, and who also qualified as an IAP experimental subject. Family strengths were explored early in the case planning process, and family therapy was an important ongoing component of the plan. Dusty's mother states that their relationship to the client manager was the most important part of the experience. The project learned to enhance this supportive dynamic in several ways. First, the client manager used special visits as strong incentives for both boys. She arranged to take the older boy to see his brother while he was at the assessment center, an unusual and highly valued privilege. As an even more creative gesture, she was able to bring Dusty's family dog on to the Lookout Mountain campus for a unique "family" visit. This family also pioneered the experiential learning activity that has become standard procedure for celebrating the transition to community placement; a ropes "challenge course" on the Lookout Mountain campus.

The challenge course consists of a set of outdoor low and high physical activities designed to stimulate problem-solving and trust-building behaviors. With help from specially trained staff, Dusty's family members, client manager, and key members of his service provider team completed a challenge program together. This shared experience became the theme for discussions of transitional problems after Dusty's move to a community-based residential program. The client manager explained that she often referred to the ropes course when discussing issues with Dusty and his mother, with statements like, "Remember, this is like the time when we needed to get Dusty across the high tightrope." The shared experience of prior shared stress in a controlled environment became a rich source of self knowledge for these family members.

During Dusty's stay in the community he went to work for his grandfather in the welding business. With clear expectations and immediate feedback for his behaviors he made gradual progress toward his goals. He was forced to take small steps towards independence even when he believed he was ready for the big ones. As he

learned his family trade and became a well-paid welder, he worked long hours at a shop on the far side of the metro area. He was denied permission to use forms of transportation other than the bus, and he was not excused from completing education and treatment assignments in addition his scheduled work time. To accommodate his own expectations and those of his transition program, he put in several months of very long, highly structured, and demanding days. A serious slip occurred one night when Dusty failed to return to the program at the required time. The client manager had to request the discretion of a local district attorney in holding back an escape charge. After this near crisis, the end of the sentence was soon reached, and Dusty moved on in a well-planned reentry to the community and freedom. Remarkably, he is now in the process of buying a home with savings he began to acquire during his community residential transition.

Not all stories will be like Dusty's. The project has seen some spectacular failures, as in the case of a boy who escaped over Lookout Mountain's security fence and was later involved in a vehicular chase, the shooting of a police officer, and an escape attempt from a county jail prior to sentencing into the adult system. While it is too early to measure the impacts of the program over time, **several observations are encouraging:**

1. **Length of stay at Lookout Mountain is shorter for the experimental group.** Even though this is not a stated goal of the project, IAP clients are generally meeting established personal goals and transitioning more quickly than control subjects.

2. **Families are reporting satisfaction with the treatment progress of their children and the important role of families in the IAP process.**

3. **The Lookout Mountain Cedar Unit and other service providers report that much more consistent and comprehensive attention is given to the IAP boys, who show many signs of progress and maturity within the program's structure.**

4. **The service provider group has produced some unanticipated benefits for the program.** Cross-training activities and service provision by community-based programs within the institution have helped to create better service and communication systems. The positive energy released by combining these teams and recognizing their efforts has helped improve staff morale and motivational levels.

5. **Transition phase activities include escorted passes to programs, family, and community activities prior to release from Lookout Mountain.**

6. **The experiential learning component is an effective rite of passage that defines the transition team and helps define relationships and expectations.**

Thanks to the long-term commitment of OJJDP, formal quantitative and qualitative research findings will be published over the next several years as an evaluation of the success of the IAP initiative.

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REFERENCE

Altschuler, D.M. & Armstrong, T.L. (1994). *Intensive Aftercare for High-Risk Juveniles: A Community Care Model. Program Summary.* Washington, DC: Office of Juvenile Justice and Delinquency Prevention, United States Department of Justice

BETHESDA FAMILY SERVICES FOUNDATION "COMMITTED TO HEALING AMERICA'S FAMILIES"

The Bethesda Day Treatment Center and its parent organization the Bethesda Family Services Foundation are committed to addressing the relational needs of troubled youth and families throughout our nation. Statistics uniformly reveal that the number of delinquent youth and distressed families in our country is increasing at an alarming rate. In order to stop the cycle of conflict that has brought so much violence into our cities, schools, and homes, the methods of intervention must be both powerful and effective. The unique strategies and comprehensive systems approach developed by Bethesda to transform the lives of troubled youth work because they are such methods.

The following background history of the Bethesda Day Treatment Program will be helpful in understanding how our techniques were developed. As the Chief Probation Officer in Central Pennsylvania for eight years, it was my desire to develop a community-based program that was both time intensive and clinically sound. The Bethesda Day Treatment Center was born out of this vision in December 1983 and shortly thereafter I resigned as Chief Probation Officer to manage the program. Our small private nonprofit corporation began with two full-time and two part-time staff serving 15-20 juveniles and their families in Central Pennsylvania. In just thirteen years the Bethesda Program evolved into six centers throughout rural and inner city Pennsylvania (including Philadelphia) and our program has been recognized as a national model by the United States Department of Justice. With our success came a variety of state and national awards including Best Community-Based Program in the Commonwealth of Pennsylvania conferred by the Pennsylvania Juvenile Court Judges' Commission and the Pennsylvania Council of Chief

Juvenile Probation Officers. In 1995, Bethesda was awarded a grant from the United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention to proceed with a national replication initiative. Throughout this growth period Bethesda was featured on four national documentaries including *Victory Over Violence* hosted by Walter Cronkite and *BAD DADS* hosted by George Foreman, both of which were produced by Arnold Shapiro Productions.

Our success lead to the development of the Bethesda Family Services Foundation which now oversees programs in Florida, Oklahoma, Maryland, Texas, Arizona and (soon) Michigan. This exponential growth is based on Bethesda's ability to develop effective treatment systems and transmit them to direct care staff through intensive training and live "hands on" demonstrations. These systems are interwoven into Bethesda's five-fold menu of treatment modules: day treatment, prep school, family systems counseling, drug and alcohol treatment, and short-term foster care.

Day treatment refers to our intensive after school, evening and weekend program which operates during nontraditional hours (Monday through Friday 2:30 P.M.-7:30 P.M. and Saturday 8:00 A.M.-2:00 P.M.).

This program includes eighteen different modalities of service including group, individual, parental and family counseling; life skills/job skills; physical activity; to mention a few.

Bethesda Prep School operates during the normal school day (8:00 A.M.-2:30 P.M.) and maintains a *no suspension/no expulsion policy*. The Bethesda Prep School offers a truly individualized educational alternative to the public school classroom. More than twenty-five public schools in Pennsylvania are purchasing educational services from Bethesda. The Bethesda Prep School combined with the after-school day treatment program allows for twelve hours of intensive intervention for each youth Monday through Friday and includes transportation. The after-school hours are modified on Wednesdays to allow caseworkers to conduct in-home visits and family counseling for their clients every week. This "lost" time is then made up on Saturday between 8:00 A.M. to 2:00 P.M.

Family Systems Counseling is the most effective form of intervention used by Bethesda. Family-Systems Counseling address the root and causal factors of the youth's antisocial behavior patterns by assessing the origin of his rage in order to lead him to the place of victory and relational healing. Further discussion of this systems approach is addressed below.

Drug and Alcohol Out-Patient Counseling. Bethesda Drug and Alcohol treatment program is our fourth program module. The Bethesda Day Treatment Center is licensed by the Pennsylvania Office of Drug and Alcohol Programs to conduct outpatient services to delinquent youth and family members who exhibit substance abuse patterns. This module is essential for a program that promises to address all of the primary behavioral and clinical needs of its clients. Bethesda has been successful where others have failed to sustain adolescent drug and alcohol groups because of its comprehensive networking in the community. Bethesda intensively penetrates the home, school, community and peer group of every youth referred for treatment and thereby enables those groups to support the treatment process.

Short Term Foster Care. When necessary, certain youth are removed from their homes and placed in short-term foster care to de-escalate potentially volatile situations. This program module is licensed by the State Department of Public Welfare.

All five of Bethesda's program modules are carefully integrated to bring about a synergistic impact upon the treatment milieu. The entire program has a much greater impact when the caseworker, the teacher, the drug and alcohol counselor, the foster care coordinator, and the family systems counselor are working in harmony under the same umbrella of services. This ensures that each youth will achieve victory and healing at an accelerated rate.

The four primary meta goals embraced by Bethesda's systems approach are known as **Bethesda's Four R's:**

- **Retribution** requires each client to take accountability and accept responsibility for his offenses;
- **Restitution** requires an apologetic message and a monetary return to victims;
- **Reconciliation** involves in-home family session that bring forth disclosure of painful memories that lead to relational healing in the home; and
- **Restoration** within the family and to the community results from the client's responsible completion of all treatment goals while enrolled in the program.

If these goals are achieved the fifth R—*recidivism*—will probably not occur. This was demonstrated by one outcome study within the first five years of the program which revealed a 10.4% recidivism rate of those youth who completed the program.

Bethesda's comprehensive program with its five-fold menu of services combined with its time intensive approach of 55 hours of weekly intervention sets it apart from other community-based models in the country. However, Bethesda's real success is found in its unique systems approach to treatment.

Bethesda recognizes the need to first control the behavior of each youth if the method of treatment is to be effective. Our **normative system**, which establishes the daily behavioral structure for those youth referred for treatment seeks to accomplish this end. In order for this system to be successful, all direct care staff must have an understanding of the normative systems concepts and its method of application. Just as system structure is effective in bringing about positive change in the lives of troubled youth, so it is that system breakdown will hinder the potential for positive change. The normative structure brings peace, order and behavioral compliance to the whole en-

vironment of the agency. It converts negative peer energy to positive peer influence and places the burden of change upon each youth which is precisely where it belongs. As the impact of the normative system unfolds there is a genuine staff-to-client bond that develops much like the trust and cohesion in a healthy family.

The second primary system of treatment is Bethesda's method of **family systems counseling** which has a demonstrated track record of bring about lasting change in the hearts and lives of troubled youth. Bethesda's unique method of family counseling engages the whole family in a thorough process of relational healing and reconciliation. The reasons this is essential to treatment is because broken relationships with the most important people in one's life will lead to internal bitterness and rage which accelerates the offending pattern. This rage must be bled out of the emotions if the troubled client is to achieve lasting change in his life. This method of counseling is both strategic and sequential as it carefully leads each client through the steps of victory and emotional healing. Bethesda's training manual and videotaped training sessions provide powerful insights into the proper applications of family systems counseling. Training teams also provide on-site demonstrations of actual counseling sessions to ensure that each counselor understands the complete process of treatment and emotional healing. In short, the normative system provides the mechanism for *external control* while the family system counseling addresses the need for *internal healing* in the lives of troubled youth.

The **Bethesda Prep School** is also carefully designed as a unique system of individualized education for those youth who have failed in the public schools. The structure and strategy ensures a completely individualized approach to academic success. Once established, the school is an orderly and peaceful learning environment for the youth and brings about a feeling of safety and security for each individual which is essential toward

developing trust between staff and clients. If youth do not feel secure or have faith in the safety of the system, they will remain withdrawn and refuse to deal with the pain in their lives. By placing troubled youth in a structured and individualized learning environment, real academic success and emotional growth can be achieved. Their faith in education is quickly restored through academic success and they are anxious to return to the public school mainstream.

This explains why Bethesda's systems approaches are now being used in secure residential centers, group homes, and detention facilities throughout the country. These systems bring about unity and cohesion among staff while significantly reducing the risk to staff and other clients. Effective systems of structure and counseling create an atmosphere which is conducive to disclosure of painful memories that might otherwise keep these youth in the bondage of emotional distress. These youth instinctively want to be helped, but not without the assurances that there is hope for victory and healing. The systems approach allows for the treatment to be conducted in a cooperative and systematic manner thereby removing the confusion that often disrupts the lives of both staff and clients alike. Everyone knows what is expected of himself and others. It removes ambiguities and stumbling blocks which hinder forward progress. It allows each one to easily monitor his journey toward the goal of positive change. Furthermore, it places the responsibility for that change upon each individual, which is where it needs to be. Everyone is taught to be accountable and responsible for his actions. Of course, all of this is amplified by the appropriate sanctions and rewards established within the normative process.

These powerful systems require hands-on assistance from Bethesda's top trainers. Bethesda's training team methodology is unique to any other in the country. With the combined expertise of several decades of experience, the Bethesda team has developed a strategy which is designed to equip professional staff to work in total harmony with one another. Bethesda trains staff to recognize and prevent potential problems before they occur. This is why an ongoing and supportive relationship between trainers and trainees was incorporated into the strategy for implementation. It removes the frustrations that so often hinder effective implementation of the treatment process. This is a cost-effective investment which ensures that Bethesda remains heavily involved during system application and less involved throughout the refining process. It unifies both casework and clinical staff in their efforts to facilitate change at an accelerated rate. The desired outcome is to have every staff member working in harmony to facilitate the same goals within the same structure. Bethesda Family Services Foundation looks forward to sharing its successful treatment methods with many more facilities throughout the United States.

Our vision for replication began in 1995 with ten cities throughout the country. Having exceeded that goal, Bethesda is challenged by a vision to reach 100 cities by the year 2000. For further information please contact the following:

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Dominic Herbst

FOURTH ANNUAL BUILDING ON FAMILY STRENGTHS CONFERENCE

The 1997 conference, ***Building on Family Strengths: Research and Services in Support of Children and Their Families***, was held May 8-10 at the Portland, Oregon Hilton Hotel. The following three themes were addressed: (1) developments in family-centered research; (2) family-centered, culturally competent services and family support; and (3) building community. A total of 420 people attended the fourth annual conference. Participants included individuals from thirty-nine states and the District of Columbia, British Columbia, the British Isles, the Republic of Palau, the Marshall Islands and Kuwait.

Nine family members were selected by their organizations to receive conference stipends for 1997: Yvonne Austin, Family Advocacy and Support Association, District of Columbia; Lori Cerar, Allies with Families, Utah; Gail Cervantes, Family Network of California; Betty Fear, Keys for Networking, Kansas; Brenda Hamilton, Family Action Network, Indiana; Charlene Harmon, Tennessee Voices for Children; Marjorie Jessup, Florida Federation of Families; Carmen Pola, Roxbury Unites for Families and Children, Massachusetts; and Lori Reynolds, Families United Network, Iowa.

The topics addressed included research on family support and family-centered care as well as descriptions of innovative programs in those topical areas. Presentations addressing the needs and experiences of families whose children and adolescents have emotional, behavioral and mental disorders were featured.

The keynote address by Carl C. Bell, M.D. was entitled *Preventing Violence: Research and Programs*. Bell, the president and chief executive officer of Community Mental Health Council in Chicago is Clinical Professor or Psychiatry and Public Health at the University of Illinois. He shared data and perspectives on the effects of violence on children, adolescents and adults and offered proposals for intervention and prevention.

Carl C. Bell, M.D.

Jenny Rodgers, Dale Gonnie, Kathleen Manolescu and Danny Kescole of the K'E Project, Tohatchi, New Mexico, presented Strengthening the Navajo Family through K'e, a reverence for all things in the universe. K'e includes maintaining balance and harmony by acknowledging and respecting clan and kinship.

Michael J. English, Director of the Division of Knowledge Development and systems Change, Center for Mental Health Services, Washington, D.C., gave a brief luncheon address describing lessons learned from family support organizations. Elaine Slaton of the Federation of Families for Children's Mental Health responded with comments from the perspective of family members.

Family members and others were encouraged to advocate for the needs of children and adolescents with special needs, including emotional and behavioral disorders, in managed care systems by a panel introduced by Barbara Huff of the Federation of Families for Children's Mental Health. Plenary panelists for the Partnerships Between Parents and Professionals in a Managed Care Environment presentation included Betsy Anderson, Family Voices, Massachusetts; Mari-Lynn Drainoni, The Medicaid Working Group, Massachusetts; Teri Sanders, Mentally Ill Kids in Distress, Arizona; and Michael Taylor, Clackamas County Mental Health, Oregon.

Conference proceedings will be published and available through the Research and Training Center. For additional information contact: Kaye Exo, Conference Coordinator, Research and Training Center on Family Support and Children's Mental Health, P.O. Box 751, Portland, Oregon 97207-0751; (503) 725-5558 (voice); (800) 735-1232 (voice); (800) 735-2900 (TT-Oregon Relay Service); (503) 725-4180 (fax); e-mail: exok@pdx.edu

SEEN AT THE CONFERENCE

Peter Marsh

Anita Noriega

Arthur Emlen

Dana Sieverin-Held

Jenny Rodgers

THE VIRGINIA INTENSIVE PAROLE PROGRAM

Virginia is one of the eight states that participated in the development of an intensive aftercare program (IAP) for high-risk juvenile offenders. The model for the program was developed by David Altschuler, Ph.D. of the Institute for Policy Studies, Johns Hopkins University, in conjunction with Troy Armstrong, Ph.D., Associate Professor at California State University at Sacramento. The Office of Juvenile Justice and Delinquency Prevention (OJJDP) funded the research and development of the model in direct response to growing concerns nationally about the high rate of recidivism, overcrowding in secure juvenile facilities, the spiraling cost of confinement, and lack of resources for aftercare services.

The Virginia Intensive Parole Program (IPP) is based on the IAP model, which is summarized on page 26. The Virginia Department of Juvenile Justice launched a prototype Intensive Parole Program (IPP) in June 1993 following training on the national IAP model. Beaumont Juvenile Correctional Center and the City of Norfolk were selected as the initial sites for implementation of the pilot. Beaumont is Virginia's largest juvenile correctional facility serving mostly older male offenders, many of whom have been committed previously. Norfolk, a metropolitan area with a population of over 263,000 (1990 census data), had the highest commitment rate in the state at the time. One hundred forty-nine youth were committed in Fiscal Year 1993. This rate increased by 65% between 1988 and 1992 as a result of escalating juvenile crime, much of it involving drug trafficking and guns. Norfolk was also selected because of its existing comprehensive interagency initiatives.

Specifically, the Norfolk Youth Network was formed. This network consists of the Norfolk Court Service Unit, Norfolk Social Services, Norfolk Public Schools, Norfolk Public Health Department, Norfolk Community Services Board (Mental Health, Substance Abuse Services and Mental Retardation Services) and Norfolk Juvenile Justice Services Bureau (detention and group home system). Several Community Assessment Teams (CATs) were created with representation from each agency to discuss multi-problem youth. These efforts initially focused on youth who had severe emotional disorders. Development of the IPP model added an emphasis on serious delinquents.

An interagency planning team, representing the different DJJ organizational entities, selected community agencies from the City of Norfolk and representatives from the Virginia Department of Correctional Education (DCE)—which provides educational services to committed juveniles—collaborated in the development of the model for nine months prior to implementation. The Virginia model initially served committed male youth from Norfolk who were age 16 or older. Sixteen is the age at which youth were likely to be placed at Beaumont Juvenile Correctional Center. The age requirement was removed in March 1996 and youth placed at Hanover Juvenile Correctional Center (often younger wards) are now also screened for the project. The youth receive specialized assessments and treatment from the point of commitment, throughout the period of confinement and upon release to parole supervision. An extensive evaluation process has been designed to measure the success of the model.

To ensure the selection of the targeted group, the model requires clearly defined selection criteria and standardized assessment to measure the criteria. Data supplied from previously committed Norfolk youth was used to develop the risk assessment instrument used to screen youth for this program. The Risk Assessment Screening Instrument focuses on six areas that were found to be most prevalent among previously committed youth who reoffended: (1) total number of offenses, (2) number of times on probation; (3) number of DJJ commitments; (4) gang involvement; (5) delinquent peer association; and (6) siblings' history of incarceration.

The risk assessment is completed at the time of commitment. For evaluation purposes, a control group of Norfolk youth with comparable scores are tracked through the institutional and parolee phases. They receive all of the required (traditional) treatment services. Their case managers typically have higher caseloads and see them less frequently.

Individual case assessments and case planning is a critical part of the IPP project and it occurs during four stages of the commitment process:

(a) the initial Community Assessment Team staffing (CAT);
(b) as part of the Reception and Diagnostic Center staffing;
(c) by the Institutional Treatment Team; and, finally,
(d) by the CAT just prior to and following release from the institution.

Upon commitment, each juvenile's case is staffed with a Norfolk CAT. The CAT includes representation from the human services agencies listed previously that are part of the Norfolk Youth Network. A parent representative also serves on the team. The CAT team reviews the status of at-risk youth in the city and assists with appropriate case planning for the youth and family. If IPP eligible, the CAT then addresses:

1. What types of treatment does the youth need while incarcerated?
2. What types of services can be offered to the family while the youth is away and what agencies are responsible for this? and
3. What types of services will the youth need upon return to the community?

This level of planning does not typically occur at this stage for the non-IPP youth.

The second assessment occurs when the youth reaches the Department of Juvenile Justice Reception and Diagnostic Center (RDC). An IPP

trained counselor is assigned. A complete assessment (physical, psychological and educational) occurs during the youth's three- to four-week stay. The youth is given an orientation to the IPP and the initial sessions of a life skills curriculum that has been developed by the IPP staff for use with these wards. At the completion of the assessment, a staffing occurs that is attended by the committing probation officer from Norfolk who presents the recommendations from the CAT. Treatment goals are identified. The IPP counselor is also present to meet the youth, to participate in goal development, and to provide an overview of the IPP process. Non-IPP youth receive the same assessments without the attendance of the IPP counselor and the committing probation officer.

The third phase includes case planning which begins with the treatment team meeting at the institution. The Norfolk IPP parole officer, the parent, the juvenile, and the IPP counselor meet with the treatment team (which consists of DCE school representatives and cottage life staff) to develop the treatment plan for the youth. The RDC evaluation results (including the CAT recommendations) are incorporated into this comprehensive plan. The plan not only includes what will happen with the youth, but also what will happen with the parents and other family members during the youth's period of incarceration.

The institutional IPP counselor serves as case manager and is responsible for implementing the treatment plan objectives that are to occur while the youth is incarcerated. There is daily contact between the counselor and the youth. The IPP counselor will follow the youth throughout his commitment, even when the youth is placed in a specialized treatment cottage with other staff assigned. Reports from treatment counselors will be forwarded to the IPP counselor. This counselor will also provide group work using the curriculum that was developed for the project.

The fourth phase of case planning begins with the CAT sixty days prior to the youth's discharge from either institution. The CAT meets to review the case, identify needs, and determine what resources will be needed for a successful reintegration into the community. The CAT is the avenue chosen to provide the hub of service brokerage and linkage for the IPP youth upon discharge from the institution. The IPP counselor may seek transitional services such as in-home counseling, additional supervision, psychological services, and individual counseling. These services may be funded either by the Department of Juvenile Justice or by the Norfolk Youth Network. They are typically funded for four to six months and may be extended. All IPP wards are transitioned through a half-way house or local group home. All necessary referrals begin at this point so that the programs are in place upon release. The CAT also reviews the case thirty days after discharge and as needed thereafter.

Treatment efforts are intensified at all points in the IPP process. While the youth is at Beaumont or Hanover, they have twice weekly counseling sessions, group sessions and daily contact with the IPP counselor. The IPP counselor has weekly contact with the parole officer, monthly contact with the parents, and participates in the CAT review and all release planning activities. The counselor makes monthly visits to Norfolk to see the parents. The counselor's caseload is limited to fifteen clients to ensure that this level of contact and service delivery can be maintained. Other institutional counselors rarely visit the communities and typically have a caseload ranging between 35-40 youth.

Upon discharge, intensified treatment efforts are implemented through a phase system of parole supervision that allows for a gradual return to the community with increased freedom and responsibility. Phase One is the Orientation Phase. This occurs the first 30-60 days of a youth's release from a juvenile correctional center. It includes placement in a half-way house, local group home or day treatment program with electronic monitoring. The parole officers work closely with the youth, the family and the staff of the placement facility to provide a smooth transition to the community.

Phase Two of the community supervision phases, known as the Freedom Phase, includes the juvenile returning home (if possible), structured daytime activities, a strict curfew, urine drug screens, frequent parole contact and surveillance and preparations for the next phase.

Phase Three, known as the Outreach and Tracking Phase, includes frequent contact from the parole officer and other service providers. A strong focus is placed on the youth's interactions with parents, the school and/or work. Mentors are used and group activities are frequent. Freedom is increased as the juvenile beings to show progress.

Phase Four, known as Regular Parole Supervision, includes a decrease in parole officer contact and a focus on completing court requirements and treatment plan goals. Community service is encouraged. Support networks should be in place and the juvenile is preparing for termination from parole. The aim is to complete all phases within six months. These phases sometimes require more time for completion.

Several efforts are in place to provide continuity in the treatment program that begins in the institution. The life skills curriculum begins for the youth at the RDC, is taught in its entirety at the Correctional Center,

and shared with the parents through group sessions while the youth is in the facility. The same curriculum continues with the youth upon release. It is facilitated by the IPP officer and reinforced by the parent. This curriculum addresses peer group issues, violence, anger control, and includes a substance abuse component.

The parole officers visit the youth while in the institution at least monthly. Their caseloads are maintained at 15 maximum (institution and community) to allow for frequent contact with the youth, parents and other service providers. As previously mentioned, the agencies represented on the CAT are responsible for identifying the services needed upon discharge. These representatives assist the Intensive Parole Officer in arranging needed services. Services are sought that specifically address the treatment needs of the offender as well as provide the appropriate amount of supervision and help prepare the youth for his overall re-integration into the community. The representatives assume responsibility for personally handling referrals within his or her agency.

A system of graduated sanctions and incentives was developed by the Norfolk Court Service unit and is used as part of the program. A list of typical offenses with corresponding sanctions was developed along with a list of rewards for the parolees when positive behaviors are exhibited. Sanctions have been developed to respond more appropriately to certain types of misconduct and technical violations. Sanctions must be swift and immediate, and they also must be graduated.

In order to use graduated sanctions effectively, there also must be a system for rewarding positive behaviors and improvement. The court service unit has attempted to incorporate into the program rewards that have some significance, importance and impact for the parolees.

The use of a system of balanced incentives and sanctions coupled with the imposition of realistic and enforceable conditions allows the parole officer to recognize immediately when infractions, as well as achievements, have taken place. In addition, it also provides the parole officer with other opportunities to impose sanctions rather than relying on filing a petition for violation of parole. The proper use of this system greatly enhances the supervision process. The institutions have a strong sanction system; however, more emphasis is now placed on the use of rewards with the IPP youth while incarcerated.

The Virginia projects remain a pilot program. We were one of four states funded with a demonstration grant from OJJDP in 1995 to fully implement the project and provide some enhancements. The program is also participating in an evaluation effort underway by the National Council on Crime and Delinquency. That effort includes a process evaluation as well as an outcome evaluation. No outcome data are yet available. The program is being implemented as designed and modifications have occurred. The management team and other agency representatives meet fairly often to discuss the program and make any necessary modifications. Elements of the community supervision phase are also being used with another intensive parole pilot project in twenty-three communities throughout Virginia. The elements seem sound; however, we continue to work with a very challenging population. The efforts of many in the community are needed to address the numerous individual and family needs of our high-risk offenders.

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REFERENCE

Altschuler, D.M. & Armstrong, T.L. (1994). Intensive Aftercare for High-Risk Juveniles: A Community Care Model. Program Summary. Washington, D.C.: Office of Juvenile Justice and Delinquency Prevention, United States Department of Justice.

SOCIAL SECURITY ADMINISTRATION ISSUES NEW RULES FOR CHILDREN'S SSI PROGRAM

The Social Security Administration (SSA) has released new interim final regulations for the children's Supplemental Security Income (SSI) program. The new rules (printed in the Federal Register on February 11, 1997) were required by the new welfare law signed by President Clinton on August 22, 1996 and became effective immediately.

Of the one million children now receiving SSI, approximately 263,000 are affected by the new eligibility rules. SSA estimates that 135,000 children will lose benefits—almost half of the children to be reviewed over the next six months will no longer qualify. SSA estimates that another 45,000 children will lose access to benefits by the year 2002, making a total of 180,000 children affected by the changes. However, some advocates believe that these numbers are very low estimates of the number of children who will lose benefits or will not be eligible in the future. Based on the SSA estimates, $4.7 billion will be cut from the program over the next six years.

KEY PROVISIONS INCLUDE THE FOLLOWING:

1. New definition of childhood disability. To qualify for disability benefits, children must have a physical or mental condition that can be medically proven and that results in "marked and severe functional limitations" of substantial duration.

2. **Individualized Functional Assessment eliminated.** The Individualized Functional Assessment (IFA), established after the 1990 U.S. Supreme Court's *Zebley* v. *Sullivan* decision, is eliminated. The IFA supplemented the listing of impairments by allowing state disability examiners to assess individually how children's disabilities affected their ability to function in various areas of daily activity.

3. **References to "maladaptive behavior" are removed from functional standards in the childhood mental impairment listings.** The new area of "personal function" indicates a child's ability to perform self-care activities—to do what is expected in areas such as personal needs, health and safety (this includes avoiding self-injurious actions). The rules clarify "social function" to include a child's capacity to form and maintain relationships with parents, other adults and peers. The new regulations make it clearer that behavioral problems, such as physical aggression or avoidance of interpersonal activities, will be evaluated as part of a child's social functioning.

4. **Loss of Medicaid coverage.** Children who lose their SSI benefits will continue to receive Medicaid if they can remain eligible on other grounds, such as their age and their family's low income. Coverage of low-income children through age 13 is now guaranteed and mandatory coverage of older children is being phased in through 2002. However, it is estimated that up to 50,000 of the children who lose SSI eligibility will lose Medicaid. The President's budget proposes that Congress allocate funds to continue Medicaid to children who lose their eligibility because of the SSI program changes. This may help children who are not eligible for Medicaid through other categories. State medical assistance agencies have been instructed to continue Medicaid while SSA reviews a child's SSI eligibility and throughout the appeal process if a child challenges the denial of SSI benefits.

5. **More frequent case reviews and new treatment requirement.** The new regulations require children to have their cases reviewed more frequently and, at the review, to show proof of treatment that is "medically necessary" and "available." Children will have their cases reviewed every three years, unless their condition is not expected to improve. Children who qualify because of their low birthweight will be reviewed 12 months after birth. Children who turn 18 will be reviewed under adult eligibility criteria within one year after their 18th birthday.

6. **Benefits paid pending appeal of SSI denials.** Children who are told that they do not qualify under the new standard may appeal. In most cases, benefits will continue throughout the appeal process until the child's representative presents his or her case in person before an administrative law judge. In addition, children are entitled to receive Medicaid pending their SSI appeal.

7. **Dedicated savings accounts are required.** Parents (or representative payees) must establish a dedicated savings account for any back benefits that exceed six times the maximum monthly payment. This money may be used only to cover specific expenses, including education or job-skills training, personal-needs assistance, special equipment or housing modifications, medical treatment, therapy or rehabilitation.

8. **Smaller benefit for children with private health insurance.** Children who are hospitalized and have private insurance to cover their medical care will receive the same $30 monthly SSI benefit that is paid to children whose medical bills are covered by Medicaid.

The law requires SSA to complete the redeterminations by August 22, 1997. Current recipients will continue receiving benefits until either July 1, 1997 or the date of redetermination, if it is later.

SOURCE:

Bazelon Center for Mental Health Law, 1101 15th Street N.W., Suite 1212, Washington, D.C. 20005-1212; (202) 467-5730 (voice); (202) 467-4232 (TDD); (202) 223-0409 (fax).

CHILD, ADOLESCENT AND FAMILY BRANCH POSITION OPENING

An opening for a project officer position for the Child and Family Mental Health Services Demonstration Program has been announced. The position is located in the Child, Adolescent and Family Branch, Division of Knowledge Development and Systems Change, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. The Child, Adolescent and Family Branch's Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Program has, since its inception in 1992, awarded twenty-two grants to states/political subdivisions or tribes to provide a broad array of community-based services for children with serious emotional, behavioral or mental disorders.

The purpose of this position is to provide substantive health administration advice and programmatic leadership to ensure that the project activities in the area of children's mental health are successfully met. The position requires monitoring and evaluating grant projects and recommending improvements to the program's project operations. Additional activities include participation in program development efforts using knowledge of successful projects and health organizations, as well as interacting with federal, state and local officials, citizen groups, professional associations and representatives from other non-profit organizations. The position is at the GS-13 level. To request a vacancy announcement and detailed salary information, contact: Anne Solomon, Division of Human Resources Management, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Room 14C, Rockville, Maryland 20857; (301) 443-5407 (voice); (301) 443-5866 (fax).

NOTES & COMMENTS

PRESIDENT CLINTON SIGNS REAUTHORIZATION OF IDEA

President Bill Clinton signed the reauthorization of the Individuals With Disabilities Education Act in a ceremony at the White House on June 4, 1997. The President noted, "For 22 years now, the IDEA has been the driving force behind the simple idea we have heard restated and symbolized here today, that every American citizen is a person of dignity and worth, having a spirit and soul, and having the right to develop his or her full capacities. Because of IDEA, disabled children all over America have a better chance to reach that capacity. And through IDEA, we recognize our common obligation to help them make the most of their God-given potential."

In reviewing the history of IDEA, President Clinton said, "Since the passage of the IDEA, 90 percent fewer developmentally disabled children are living in institutions; hundreds of thousands of children with disabilities attend public schools and regular classrooms; three times as many disabled young people are enrolled in colleges and universities; twice as many young Americans with disabilities in their twenties are in the American workplace. We have to continue to push these trends, to do everything we can to encourage our children with disabilities not only to dream of doing great things, but to live out their dreams."

Key provisions of the bill include:

- improving and strengthening individualized education programs by relating a child's education to what children without disabilities receive in the general curriculum, ensuring accountability for results (children receive report cards), and transition planning beginning at age fourteen, and including special considerations (e.g., considering a child's need for assistive technology and considering the need for behavioral intervention strategies);
- ensuring parental consent for triennial IEP re-evaluations (not just initial evaluations) and ensuring that evaluations are relevant to the child's instructional needs;
- requiring the inclusion of parents in IEP group-making placement decisions about their child;
- clarifying that infants and toddlers receiving early intervention services should receive services in natural environments (e.g., their homes) where appropriate;
- specifying that parents may be reimbursed for the costs of private placements when a due process hearing examiner or judge determines that their child was not provided a free appropriate public education by the public agency; and
- authorizing the Secretary of Health and Human Services to fund states interested in developing or expanding programs of support to families who want to keep their children with severe disabilities at home.

Disciplinary safeguards include:

(1) providing school personnel with the authority to remove a child from his or her current placement into an interim alternative educational setting for up to 45 days if the child carries a weapon or knowingly possesses, uses or sells illegal drugs or controlled substances (current law limits this authority to guns); and (2) authorizing the removal of a child from his or her current educational setting into an interim alternative educational setting for up to 45 days from a hearing examiner, if they can demonstrate that maintaining the child in the child's current placement is substantially likely to result in injury to the child or others (under current law, only a court has this authority); and (3) subject to specified limitation, authorizing school officials who do not have knowledge or could not reasonably have known that a child has a disability prior to taking disciplinary action against the child, to subject the child to the same disciplinary measures applied to children without disabilities engaging in comparable behaviors.

FAREWELL, RAE ANNE!

Rae Anne Lafrenz

Rae Anne Lafrenz left the Research and Training Center in April after two years service with us as an office specialist. In addition to a variety of other tasks, Rae Anne maintained the Center's 26,000 person mailing list, assisted with purchasing and travel arrangements, kept track of many conference details, and contributed to the production of a number of Center publications. She gave us her warm friendship and kept us up-to-date about the world of rock and roll.

Rae Anne has joined the Peace Corps and will serve as an agricultural specialist for two years in El Salvador. We miss Rae Anne and wish her the best of luck in the future.

TRAINING INSTITUTES ON SYSTEMS OF CARE FOR CHILDREN PLANNED FOR JUNE 1998

An important upcoming event will provide an intensive training opportunity for a wide range of participants. The biennial **Training Institutes** are scheduled for **June 13–17, 1998** and will be held in Orlando, Florida at the Omni Rosen Hotel.

The 1996 Training Institutes, held in Traverse City, Michigan, were attended by 1300 individuals, confirming an extraordinary level of interest in training related to the development of systems of care. Accordingly, the 1998 Training Institutes will focus on ***Developing Local Systems of Care for Children and Adolescents with Severe Emotional Disturbances*** and will offer an opportunity to obtain in-depth, practical information on how to develop, organize, and operate comprehensive, coordinated, community-based, family-focused systems of care for children and their families. A major focus on developing systems of care in a managed care environment is planned for the 1998 Institutes.

The Institutes are designed for a variety of individuals including state and local administrators, planners, providers, parents, and advocates. A primary target group consists of agency administrators, managers, providers, and parents from local areas, representing mental health and other child-serving agencies. These individuals, ideally attending as a team, are the ones who can take the knowledge and skills developed at the Institutes and begin to apply it in their home communities. This training can be an invaluable experience for a community that is planning a system improvement initiative.

The Institutes are sponsored by the National Technical Assistance Center for Children's Mental Health at Georgetown University and are funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. For more information contact the National Technical Assistance Center for Children's Mental Health, 3307 M Street NW, Washington, DC 20007, (202) 687-5000.

NEW STRENGTHS-BASED ASSESSMENT INSTRUMENT AVAILABLE

Designed for use in schools, mental health clinics, and child welfare agencies, and other social services agencies, the Behavioral and Emotional Rating Scale (BERS) helps to measure the emotional and behavioral strengths of children and adolescents. The BERS includes 52 items that assess five dimensions of a child's strength: (1) interpersonal strength; (2) family involvement; (3) intrapersonal strength; (4) school functioning; and (5) affective strength. The BERS is useful in identifying the emotional and behavioral strengths of children, the areas in which individual strengths need to be developed, and the goals for individual treatment plans. Also, the BERS is useful in evaluating children referred for services and the outcomes of the services they receive. The scale can be completed in approximately ten minutes by teachers, parents, counselors or other persons knowledgeable about the child. The BERS provides an overall strength score and five subtest scores.

National norms were established by having several hundred clinicians, teachers, and parents complete the BERS on children with whom they work or live. Ratings were received on a nationally representative sample of 2,100 children without disabilities, and a national sample of 900 children with emotional and behavioral disorders. Based on these data, norms for children without disabilities (5-18 years of age) were established as well as norms for children with emotional and behavioral disorders.

Demographics of the standardization sample are reported in the manual by age, gender, geographic location, race, ethnicity, and socio-economic status. Separate norms are available for children diagnosed with emotional and behavioral disorders.

The BERS is copyrighted and was published in 1997 by PRO-ED. An administration, scoring and interpretation manual, as well as 50 BERS scales, are available for purchase. For ordering information contact: PRO-ED, 8700 Shoal Creek Blvd., Austin, Texas 78757; voice: (800) 897-3202; fax: (512) 451-8542.

FEDERATION OF FAMILIES FOR CHILDREN'S MENTAL HEALTH HOLDS EIGHTH ANNUAL CONFERENCE

The Federation of Families for Children's Mental Health held its eighth annual conference in Arlington, Virginia, November 13-17, 1996. Nearly 900 people attended the full conference entitled ***Ahead of the Curve: Maximizing Learning Opportunities for Children and Youth with Emotional, Behavioral and Mental Disorders.*** Jonathan Kozol, author of *Amazing Grace* and other crusading books about blighted urban classrooms, adult literacy, homeless shelters and under-funded public schools opened the conference. His presentation focused on a renewed focus on the needs of the underserved in America. Workshop participants had the opportunity to choose from over 40 workshops focusing on such topics as transition services, legislative advocacy, cultural diversity, reaching migrant families, school-based services, wrap-around services and more. The workshops followed the conference theme of maximizing learning opportunities for youth with emotional, behavioral and mental disorders.

Al Guida, Director of Government Affairs, National Mental Health Association was recognized for his tireless efforts to assure continued federal funding for mental health and family organizations.

The 1996 "Claiming Children" award" was given to Norma Mateo, a family member from Chicago, Illinois who exemplifies the spirit of family advocacy in her own work. The 1996 "Make A Difference" award was given to Cynthia Wainscott of Atlanta, Georgia. This award is given to a professional who promotes the involvement of families in improving the design and delivery of service to families who have children or adolescents with behavioral, emotional or mental disorders. One of the many highlights of the conference was the beautiful artwork and a workshop led by the Young Graffiti Masters, a talented group of Graffiti Masters from Boston, Massachusetts. One of the outstanding trends at the Federation of Families Conference in 1996 was youth involvement on many levels.

TENTH ANNUAL RESEARCH CONFERENCE CELEBRATES A DECADE OF IMPROVING CHILDREN'S MENTAL HEALTH SERVICE SYSTEMS

Historically, research on children's mental health services lagged behind that addressing adult services. Over the past decade, however, the annual research conference, ***A System of Care for Children's Mental Health***, has championed research in support of the children's mental health

movement. As a result, knowledge about what works for children with serious emotional disorders has advanced rapidly. Sponsored by the Research and Training Center for Children's Mental Health, University of South Florida, the conference's mission has been to "build and support the newly evolving system of care research and to promote the growth and capacity of the field," said Center Director Robert Friedman.

The role of this research gains importance in light of managed care, state accountability measures, and the decreased federal role in service provision. During the opening session, *A Look Into the Future: Developing and Evaluating Systems of Care*, Center Advisory Board member Chris Koyanagi, Judge Bazelon Center for Mental Health Law, stressed that the children's mental health field must again demonstrate that children do have emotional disturbances, and that there are services that work. She charged today's researchers to provide the effectiveness and outcome data that will relate to today's policy questions, such as changes in Supplemental Security Income and juvenile justice. "We need research that is quick on its feet," said Koyanagi.

A national network of 650 administrators, policymakers, providers, researchers, family members and advocates attended the February 1997 conference. In addition to 200 presentations featuring findings from current initiatives, the conference offered intensive workshops on methodology in response to requests for hands-on instruction in contemporary research and evaluation methods. Conference proceedings are available on the Center's World Wide Web site. For additional information contact: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Louis de la Parte Florida Mental Health Institute, University of South Florida, 13301 Bruce B. Downs Blvd., Tampa, Florida 33612-3899; (813) 974-4433 (voice); (813) 974-4406 (fax); e-mail: resnet.fmhi.usf.edu; World Wide Web: http://lumpy.fmhi.usf.edu/cfsroot/rtc/rtchome.html

ROLANDO SANTIAGO JOINS CHILD, ADOLESCENT AND FAMILY BRANCH

Dr. Rolando L. Santiago has been appointed Evaluator for the Child, Adolescent and Family Branch (CAFB) of the Division of Knowledge Development and System Change at the Center for Mental Health Services. He will share responsibility for the design, implementation, and reporting of activities in CAFB related programs. Rolando will also use his evaluation skills to assist grantees and contractors in achieving project and program goals. He will examine the data generated by programs and recommend results appropriate for reporting to Congress and other audiences. Rolando starts his responsibilities with the CAFB on September 2, 1997.

Rolando has served as Project Evaluator for the Families Reaching in Ever New Directions (FRIENDS) Initiative in the Mott Haven community of the South Bronx since December 1994. FRIENDS is one of 22 grantee sites of the Comprehensive Community Mental Health Services Program for Children funded by the CAFB. In addition to implementing the national evaluation in Mott Haven, Rolando incorporated several features into the evaluation that enhanced the role of parents, strengthened the design, created a tracking system, increased sensitivity to culture and established rigorous data collection training.

During his time as Evaluator for the FRIENDS Initiative, Rolando held the position of Research Scientist at the New York State Office of Mental Health. Prior to joining that office, his experience in evaluation and research in the human services and education was extensive. As a research consultant, he designed and directed a longitudinal study to investigate the degree to which developmental scores taken at infancy related to measures of school performance obtained in kindergarten. He also conducted a field study of energy education materials among middle school children, analyzed results of a sociolinguistic study among 500 Hispanic adolescents in over 10 cities in the U.S., analyzed cultural-based stories written in both Spanish and English by Hispanic middle schoolers; and evaluated a short-term group therapy program for Lupus patients.

Rolando received his doctorate in 1994 from the Department of Educational Psychology and Statistics at the University of Albany, State University of New York, where his concentration was child development and learning, with emphasis on statistics and measurement. His doctoral research focused on the interrelationship between linguistic performance, cognitive performance, and the home language environment among Spanish-English bilingual preschool and kindergarten children.

Rolando believes that the main goal of an evaluation is to identify changes in the components of a managed system of care that relate to positive outcomes for children, families, services and the community. This goal derives from his view that "children become mentally healthy as they interact with environments that include empowered families, quality services and supportive communities."

NAMI ANNUAL MEETING

The 1997 National Alliance for the Mentally Ill's annual convention will be held at the Albuquerque, New Mexico Convention Center July 10-13, 1997. Two pre-conferences will be held on July 9th: (1) NAMI's Leadership Training Conference: Growing AMI Capacity Across America; and (2) a conference for adult offspring and siblings of people with brain disorders. Sessions of interest to parents will be presented throughout the four-day convention. For more information on the convention please contact: Convention Department, National Alliance for the Mentally Ill, 200 N. Glebe Road, Suite 1015, Arlington, Virginia 22203-3754; voice: (703) 524-7600; fax: (703) 524-9094.

PUBLICATIONS

❒ **AN INTRODUCTION TO CULTURAL COMPETENCE PRINCIPLES AND ELEMENTS: AN ANNOTATED BIBLIOGRAPHY.** *Describes articles & books that exemplify aspects of the CASSP cultural competence model.* **$6.50**

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